State of Connecticut
Department of Developmental Services

Dannel P. Malloy
Governor

Terrence W. Macy, Ph.D.
Commissioner

Joseph W. Drexler, Esq.
Deputy Commissioner

October 1, 2012

DDS Legislative Proposals for the 2013 Legislative Session (in priority order):

1. An Act Concerning Self Advocates Employed by the Department of Developmental Services
2. An Act Concerning Intermediate Care Facilities for Individuals with Intellectual Disabilities
3. An Act Concerning Revisions to Various Councils by the Department of Developmental Services
4. An Act Eliminating a Reporting Requirement

Please contact Rod O'Connor, Legislative Liaison at 418-6130 or rod.oconnor@ct.gov with any questions regarding these proposals.

Phone: 860 418-6000 ◆ TDD 860 418-6079 ◆ Fax: 860 418-6001
460 Capitol Avenue ◆ Hartford, Connecticut 06106
www.ct.gov/dds ◆ e-mail: ddsct.co@ct.gov

Agency Legislative Proposal - 2013 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
10-1-12 DDS Self Advocates

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Department of Developmental Services (DDS)

Liaison: Rod O'Connor
Phone: 860-418-6130
E-mail: rod.oconnor@ct.gov

Lead agency division requesting this proposal: DDS Human Resources

Agency Analyst/Drafter of Proposal: Gerry Daley, Director of DDS Human Resources

Title of Proposal An Act Concerning Self Advocates Employed by the Department of Developmental Services

Statutory Reference Section 5-198 CGS

Proposal Summary
This legislative proposal would make DDS self-advocate coordinators exempt from state classified service. This would allow the DAS job spec for this position to be re-written to allow for a potential pay increase and increase in hours for the DDS self-advocate coordinators. This would work towards the Commissioner's goal of employing persons with intellectual disability at competitive wages and having the DDS self-advocate coordinators be an integral part of implementing the goals of the DDS Five Year Plan.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
No

(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
No

(3) Have certain constituencies called for this action?
Yes, the Commissioner, in the DDS Five Year Plan, has emphasized both having DDS consumers and their families take an increasing role in how the agency provides supports and services and that employment for persons with intellectual disability should be for competitive wages and

benefits. The Self-Advocate Coordinators, who would benefit from a re-written job spec, which this proposal would allow are paid employees of the department as well as being DDS consumers. The self advocates help consumers and families by doing trainings, holding information sessions and getting the word out about living and working in the community in the least restrictive setting.

(4) ***What would happen if this was not enacted in law this session?*** *Self-Advocate Coordinators would continue to work at their current rate of pay under their current job spec.*

- **Origin of Proposal** **_X_ New Proposal** **___ Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Department of Administrative Services
Agency Contact (name, title, phone): Andrea Keilty, Policy & Legislative Advisor (860) 713-5267

Date Contacted: 10-1-12

Approve of Proposal ___ YES ___NO _X_ Talks Ongoing

Summary of Affected Agency's Comments

Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) None

State: None

Federal: None

Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

This proposal would make DDS self-advocate coordinators exempt from state classified service. This would allow the DAS job spec for this position to be re-written to allow for a potential pay increase and increase in hours for the DDS self-advocate coordinators. This proposal is part of the Commissioner's plan to increase direct involvement of individuals and families, consistent with the new DDS Mission and Values and Five Year Plan by enhancing the role of DDS Self Advocate Coordinators.

An Act Concerning Self Advocates Employed by the Department of Developmental Services.

Be it enacted by the Senate and House of Representatives in the General Assembly Convened:

Section 5-198 of the 2012 supplement to the general statutes, as amended by Public Act 12-205 and Public Act 12-1 of the June 12 Special Session, is repealed and the following is substituted in lieu thereof:

Sec. **5-198**. Positions exempt from classified service. The offices and positions filled by the following-described incumbents shall be exempt from the classified service:

(1) All officers and employees of the Judicial Department;

(2) All officers and employees of the Legislative Department;

(3) All officers elected by popular vote;

(4) All agency heads, members of boards and commissions and other officers appointed by the Governor;

(5) All persons designated by name in any special act to hold any state office;

(6) All officers, noncommissioned officers and enlisted men in the military or naval service of the state and under military or naval discipline and control;

(7) (A) All correctional wardens, as provided in section 18-82, and (B) all superintendents of state institutions, the State Librarian, the president of The University of Connecticut and any other commissioner or administrative head of a state department or institution who is appointed by a board or commission responsible by statute for the administration of such department or institution;

(8) The State Historian appointed by the State Library Board;

(9) Deputies to the administrative head of each department or institution designated by statute to act for and perform all of the duties of such administrative head during such administrative head's absence or incapacity;

(10) Executive assistants to each state elective officer and each department head, as defined in section 4-5, provided each position of executive assistant shall have been created in accordance with section 5-214;

(11) One personal secretary to the administrative head and to each undersecretary or deputy to such head of each department or institution provided any classified employee whose position is affected by this subsection shall retain classified status in such position;

(12) All members of the professional and technical staffs of the constituent units of the state system of higher education, as defined in section 10a-1, of all other state institutions of learning, of the Board of Regents for Higher Education, and of the agricultural experiment station at New Haven, professional and managerial employees of the Department of Education and teachers certified by the State Board of Education and employed in teaching positions at state institutions;

(13) Physicians, dentists, student nurses in institutions and other professional specialists who are employed on a part-time basis;

(14) Persons employed to make or conduct a special inquiry, investigation, examination or installation;

(15) Students in educational institutions who are employed on a part-time basis;

(16) Forest fire wardens provided for by section 23-36;

(17) Patients or inmates of state institutions who receive compensation for services rendered therein;

(18) Employees of the Governor including employees working at the executive office, official executive residence at 990 Prospect Avenue, Hartford and the Washington D. C. office;

(19) Persons filling positions expressly exempted by statute from the classified service;

(20) Librarians employed by the State Board of Education or any constituent unit of the state system of higher education;

(21) All officers and employees of the Division of Criminal Justice;

(22) Professional employees in the education professions bargaining unit of the Department of Rehabilitation Services;

(23) Lieutenant colonels in the Division of State Police within the Department of Emergency Services and Public Protection appointed on or after June 6, 1990;

(24) The Deputy State Fire Marshal within the Department of Construction Services;

(25) The chief administrative officer of the Workers' Compensation Commission;

(26) Employees in the education professions bargaining unit;

(27) Disability policy specialists employed by the Council on Developmental Disabilities; and

(28) The director for digital media and motion picture activities in the Department of Economic and Community Development.

(29) General Workers, not to exceed eleven, employed by the Department of Developmental Services as self-advocates.

Agency Legislative Proposal - 2013 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
10-1-12 DDS ICF/IID

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Department of Developmental Services (DDS)

Liaison: Rod O'Connor
Phone: 860-418-6130
E-mail: rod.oconnor@ct.gov

Lead agency division requesting this proposal: Commissioner's Office

Agency Analyst/Drafter of Proposal: Rod O'Connor

Title of Proposal
An Act Concerning Intermediate Care Facilities for Individuals with Intellectual Disabilities

Statutory References: Sections 17a-220, 17a-238, 17b-99a, 17b-106, 17b-244a, 17b-260d, 17b-278, 17b-280, 17b-340, 17b-340a, 17b-340b, 17b-352, 17b-356, 17b-363b, 19a-490, 19a-491c, and 19a-638.

Proposal Summary
This proposal would change the term "Intermediate Care Facility for the Mentally Retarded (ICF/MR)" to the federally sanctioned term "Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)." It also replaces the term "residential facility for the mentally retarded" with "residential facility for persons with intellectual disability." This is part the department's on-going effort to use respectful and "person first" language and to eliminate the use of the term "mental retardation" in statute.
The Centers for Medicare & Medicaid Services (CMS), HHS. Final Rule that was effective July 16, 2012 changes the term ICF/MR to ICF/IID and changes the term "mental retardation" to "intellectual disability" along with the use of "person first" language. (See attached rule.)

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
There has been a CMS rule change in terminology from "ICF/MR" to "ICF/IID" and from "mental retardation" to "intellectual disability."

(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
Probably not because of the implementation date of the federal rule, which is July 16, 2012

(3) Have certain constituencies called for this action?

DDS self-advocates, DDS consumers and families and DDS employees have backed previous respectful language and "person first" changes to the statutes.

(4) What would happen if this was not enacted in law this session?
DDS would be back again next year with the same proposal. CT statutes would not be in line with federal terminology.

- **Origin of Proposal** _X_ **New Proposal** ___ **Resubmission**

If this is a resubmission, please share:
(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: DSS, DPH
Agency Contact (name, title, phone): Carolyn Treiss (DSS), Jill Kentfield (DPH)
Date Contacted: 9-24-12, 9-28-12

Approve of Proposal _X_ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments
Not a problem because CMS has changed the terminology.

Will there need to be further negotiation? ___ YES _X_NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)
None.

State
Minimal. Agency documents may need to incorporate terminology changes.

Federal
None.

Additional notes on fiscal impact

Policy and Programmatic Impacts (Please specify the proposal section associated with the impact)
Connecticut state agencies would be using current federal terminology in working with CMS and HHS. Connecticut would be a leader in removing stigmatizing and inappropriate terminology from its statutes.

An Act Concerning Intermediate Care Facilities for Individuals with Intellectual Disabilities

Be it enacted by the Senate and House of Representatives in the General Assembly Convened:

Section 1. Section 17a-220 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 17a-220. (Formerly Sec. 19a-464c). Definitions. As used in this section and sections 17a-221 to 17a-225, inclusive:

(1) "Borrower" means an organization which has received a loan pursuant to this section and sections 17a-221 to 17a-225, inclusive;

(2) "Capital loan agreement" means an agreement, in the form of a written contract, between the department and the organization which sets forth the terms and conditions applicable to the awarding of a community residential facility loan;

(3) "Certification" or "certified" means certification by the Department of Public Health as an intermediate care facility for [the mentally retarded] individuals with intellectual disabilities pursuant to standards set forth in the rules and regulations published in Title 42, Part 442, Subpart G of the Code of Federal Regulations;

(4) "Community-based" means those programs or facilities which are not located on the grounds of, or operated by, the department;

(5) "Community residential facility" means a community-based residential facility which houses up to six persons with intellectual disability or autism spectrum disorder and which provides food, shelter, personal guidance and, to the extent necessary, continuing health-related services and care for persons requiring assistance to live in the community, provided any such facilities in operation on July 1, 1985, which house more than six persons with intellectual disability or autism spectrum disorder shall be eligible for loans for rehabilitation under this section and sections 17a-221 to 17a-225, inclusive. Such facility shall be licensed and may be certified;

(6) "Community Residential Facility Revolving Loan Fund" means the loan fund established pursuant to section 17a-221;

(7) "Default" means the failure of the borrower to observe or perform any covenant or condition under the capital loan agreement and includes the failure to meet any of the conditions specified in section 17a-223;

(8) "Department" means the Department of Developmental Services;

(9) "Loan" means a community residential facilities loan which shall bear an interest rate to be determined in accordance with subsection (t) of section 3-20, but in no event in excess of six per cent per annum, and is made pursuant to the provisions of this section and sections 17a-221 to 17a-225, inclusive;

(10) "Licensed" or "licensure" means licensure by the department pursuant to section 17a-227;

(11) "Organization" means a private nonprofit corporation which is (A) tax-exempt under Section 501(c)(3) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended, (B) qualified to do business in this state, and (C) applying for a loan under the community residential facility revolving loan program;

(12) "Rehabilitate" or "rehabilitation" means rehabilitation of a previously existing and operating community residential facility to meet physical plant requirements for licensure, certification or Fire Safety Code compliance or to make energy conservation improvements;

(13) "Renovate" or "renovation" means renovation of a newly acquired residential facility to meet physical plant requirements for licensure, certification or Fire Safety Code compliance or to make energy conservation improvements;

(14) "Total property development cost" means the cost of property acquisition, construction, renovation or rehabilitation and related development costs which may be capitalized under generally accepted accounting principles, including furnishings and equipment, provided in no case may the total property development cost of a residential facility financed pursuant to this section and sections 17a-221 to 17a-225, inclusive, exceed the total residential development amount approved by the Department of Social Services in accordance with sections 17a-228 and 17b-244, and the regulations adopted thereunder; and

(15) "Capital repairs and improvements" means major repairs and improvements to an existing community residential facility to maintain the physical plant and property of such facility, which repairs and improvements are reimbursable under the room and board rates established by the Department of Social Services in accordance with section 17b-244 and may be capitalized in accordance with generally accepted accounting principles.

Section 2. Section 17a-228 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 17a-228. (Formerly Sec. 19a-483). Payments for room and board and other services for persons with intellectual disability in residential facilities. Authorization for admission to residential facilities; annual review. (a) If a person with intellectual disability residing in a residential facility for persons with intellectual disability licensed pursuant to section 17a-227, but not certified to participate in the Title XIX Medicaid program as an intermediate care facility for [the mentally retarded,] individuals with intellectual disabilities, qualifies for the program of state supplementation to the Supplemental Security Income Program, the Commissioner of Social Services shall pay, under such qualifying program, on behalf of such person the rate established pursuant to subsection (b) of section 17b-244 for room and board, after a reasonable deduction, as determined by the commissioner, to reflect such person's income. The Department of Developmental Services shall pay the rate established pursuant to subsection (b) of section 17b-244 for services other than room and board provided on behalf of any person whose admission to the facility has been authorized by the Department of Developmental Services.

(b) Notwithstanding the provisions of subsection (a) of this section, persons residing in residential facilities for persons with intellectual disability licensed pursuant to section 17a-227 and receiving state payment for the cost of such services on October 1, 1983, shall be deemed to have been authorized for admission by the Department of Developmental Services. In addition, any person who is admitted to a residential facility for persons with intellectual disability after October 1, 1983, and not later than December 31, 1983, which facility is licensed pursuant to said section after October 1, 1983, and who is receiving state payment for the cost of such services, shall be deemed to have been authorized for admission by the Department of Developmental Services if (1) not later than July 15, 1983, the applicant for licensure owns or has an interest in the facility or land upon which the facility shall be located, or concludes a closing transaction on any mortgage loan secured by mortgage on such facility or land, (2) such facility is licensed not later than December 31, 1983, and (3) the applicant for licensure presents evidence to the Commissioner of Developmental Services that commitments had been made by such applicant not later than July 15, 1983, for the placement of individuals in such facility.

(c) The Department of Social Services shall continue to make payments on behalf of persons residing, on or before October 1, 1983, in residential facilities licensed pursuant to section 17a-227 on or before October 1, 1983, but not certified as intermediate care facilities for [the mentally retarded,] individuals with intellectual disabilities, and on behalf of persons authorized for admission into such facilities by the Department of Developmental Services after October 1, 1983, who are otherwise eligible for assistance under sections 17b-600 to 17b-604, inclusive. Such payment shall be on the same basis and at the same rate which is in effect on October 1, 1983, and shall continue to pay such rate until the next succeeding annual rate is determined as provided in section 17b-244 and in this section.

(d) Each individual authorized for admission pursuant to subsections (a) or (b) of this section into a residential facility for persons with intellectual disability licensed pursuant to section 17a-227 shall be reviewed annually by the Department of Developmental Services. Upon completion of the annual review, the Department of Developmental Services may (1) renew the authorization of the individual for continued state-assisted care in the residential facility, (2) refuse to renew the authorization of the individual for continued state-assisted care in the residential facility but authorize admission into alternate facilities, or (3) refuse to renew the authorization of the individual for continued state-assisted care in the facility and refuse to authorize continued state-assisted care in alternate facilities. If the Department of Developmental Services refuses to renew the authorization of the individual for continued state-assisted care in the residential facility and either authorizes admission into alternative facilities or refuses to authorize the individual for state-assisted care in any such alternative facility, the Department of Developmental Services shall continue to pay the rate established pursuant to section 17b-244 for such time as may be administratively necessary for the Department of Developmental Services to arrange for an appropriate transfer.

(e) Whenever the Department of Developmental Services refuses to renew the authorization of a person for continued state-assisted care in a licensed residential facility for persons with intellectual disability pursuant to subsection (d) of this section and either authorizes the individual for admission into alternate facilities or refuses to authorize the individual for continued state-assisted care in any alternative facility, the Department of Developmental Services shall give thirty days' notice of its determination to the previously authorized individual and to such individual's parent, conservator, guardian or other legal representative. Such notice shall also notify each such individual or his legal representative of the individual's right to contest the determination by submitting a request for a hearing in writing to the Commissioner of Developmental Services not later than fifteen days after the date of receiving the notice required by this subsection. Such hearing, if requested, shall be conducted in accordance with the provisions of sections 4-176e to 4-184, inclusive. State-assisted care shall continue in the present facility pending final disposition of any such hearing.

(f) Whenever the Department of Social Services is notified that a facility receiving payments from the Department of Developmental Services under the provisions of this section has been certified as an intermediate care facility for persons with mental retardation, as defined in 42 CFR 440.50, the Commissioner of Social Services shall notify the Governor and the Governor, with the approval of the Finance Advisory Committee, may transfer from the appropriation for the Department of Developmental Services to the Department of Social Services, sufficient funds to cover the cost of all services previously paid by the Department of Developmental Services that are reimbursable, at the rate established for services provided by such certified facilities. Subsequent budget requests from both departments shall reflect such transfer of responsibility.

Section 3. Section 17b-99a of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 17b-99a. Audits of long-term care facilities. (a)(1) For purposes of this section, "facility" means any facility described in this subsection and for which rates are established pursuant to section 17b-340.

(2) The Commissioner of Social Services shall conduct any audit of a licensed chronic and convalescent nursing home, chronic disease hospital associated with a chronic and convalescent nursing home, a rest home with nursing supervision, a licensed residential care home, as defined in section 19a-490, and a residential facility for [the mentally retarded] persons with intellectual disability which is licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for [the mentally retarded] individuals with intellectual disabilities in accordance with the provisions of this section.

(b) Not less than thirty days prior to the commencement of any such audit, the commissioner shall provide written notification of the audit to such facility, unless the commissioner makes a good-faith determination that (1) the health or safety of a recipient of services is at risk; or (2) the facility is engaging in vendor fraud under sections 53a-290 to 53a-296, inclusive.

(c) Any clerical error, including, but not limited to, recordkeeping, typographical, scrivener's or computer error, discovered in a record or document produced for any such audit, shall not of itself constitute a wilful violation of the rules of a medical assistance program administered by the Department of Social Services unless proof of intent to commit fraud or otherwise violate program rules is established.

(d) A finding of overpayment or underpayment to such facility shall not be based on extrapolated projections unless (1) there is a sustained or high level of payment error involving the facility, (2) documented educational intervention has failed to correct the level of payment error, or (3) the value of the claims in aggregate exceeds one hundred fifty thousand dollars on an annual basis.

(e) A facility, in complying with the requirements of any such audit, shall be allowed not less than thirty days to provide documentation in connection with any discrepancy discovered and brought to the attention of such facility in the course of any such audit.

(f) The commissioner shall produce a preliminary written report concerning any audit conducted pursuant to this section and such preliminary report shall be provided to the facility that was the subject of the audit not later than sixty days after the conclusion of such audit.

(g) The commissioner shall, following the issuance of the preliminary report pursuant to subsection (f) of this section, hold an exit conference with any facility that was the subject of any audit pursuant to this subsection for the purpose of discussing the preliminary report.

(h) The commissioner shall produce a final written report concerning any audit conducted pursuant to this subsection. Such final written report shall be provided to the facility that was the subject of the audit not later than sixty days after the date of the exit conference conducted pursuant to

subsection (g) of this section, unless the commissioner and the facility agree to a later date or there are other referrals or investigations pending concerning the facility.

(i) Any facility aggrieved by a final report issued pursuant to subsection (h) of this section may request a rehearing. A rehearing shall be held by the commissioner or the commissioner's designee, provided a detailed written description of all items of aggrievement in the final report is filed by the facility not later than ninety days following the date of written notice of the commissioner's decision. The rehearing shall be held not later than thirty days following the date of filing of the detailed written description of each specific item of aggrievement. The commissioner shall issue a final decision not later than sixty days following the close of evidence or the date on which final briefs are filed, whichever occurs later. Any items not resolved at such rehearing to the satisfaction of the facility or the commissioner shall be submitted to binding arbitration by an arbitration board consisting of one member appointed by the facility, one member appointed by the commissioner and one member appointed by the Chief Court Administrator from among the retired judges of the Superior Court, which retired judge shall be compensated for his services on such board in the same manner as a state referee is compensated for his services under section 52-434. The proceedings of the arbitration board and any decisions rendered by such board shall be conducted in accordance with the provisions of the Social Security Act, 42 USC 1396, as amended from time to time, and chapter 54.

(j) The submission of any false or misleading fiscal information or data to the commissioner shall be grounds for suspension of payments by the state under sections 17b-239 to 17b-246, inclusive, and sections 17b-340 and 17b-343, in accordance with regulations adopted by the commissioner. In addition, any person, including any corporation, who knowingly makes or causes to be made any false or misleading statement or who knowingly submits false or misleading fiscal information or data on the forms approved by the commissioner shall be guilty of a class D felony.

(k) The commissioner, or any agent authorized by the commissioner to conduct any inquiry, investigation or hearing under the provisions of this section, shall have power to administer oaths and take testimony under oath relative to the matter of inquiry or investigation. At any hearing ordered by the commissioner, the commissioner or such agent having authority by law to issue such process may subpoena witnesses and require the production of records, papers and documents pertinent to such inquiry. If any person disobeys such process or, having appeared in obedience thereto, refuses to answer any pertinent question put to the person by the commissioner or the commissioner's authorized agent or to produce any records and papers pursuant thereto, the commissioner or the commissioner's agent may apply to the superior court for the judicial district of Hartford or for the judicial district wherein the person resides or wherein the business has been conducted, or to any judge of such court if the same is not in session, setting forth such disobedience to process or refusal to answer, and such court or judge shall cite such person to appear before such court or judge to answer such question or to produce such records and papers.

Section 4. Section 17b-106 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 17b-106. (Formerly Sec. 17-12f). State supplement to Supplemental Security Income Program. Unearned income disregard. Adult payment standards. State supplement payments for certain residents in long-term care facilities. (a) On January 1, 2006, and on each January first thereafter, the Commissioner of Social Services shall increase the unearned income disregard for recipients of the state supplement to the federal Supplemental Security Income Program by an amount equal to the federal cost-of-living adjustment, if any, provided to recipients of federal Supplemental Security Income Program benefits for the corresponding calendar year. On July 1, 1989, and annually thereafter, the commissioner shall increase the adult payment standards over those of the previous fiscal year for the state supplement to the federal Supplemental Security Income Program by the percentage increase, if any, in the most recent calendar year average in the consumer price index for urban consumers over the average for the previous calendar year, provided the annual increase, if any, shall not exceed five per cent, except that the adult payment standards for the fiscal years ending June 30, 1993, June 30, 1994, June 30, 1995, June 30, 1996, June 30, 1997, June 30, 1998, June 30, 1999, June 30, 2000, June 30, 2001, June 30, 2002, June 30, 2003, June 30, 2004, June 30, 2005, June 30, 2006, June 30, 2007, June 30, 2008, June 30, 2009, June 30, 2010, June 30, 2011, June 30, 2012, and June 30, 2013, shall not be increased. Effective October 1, 1991, the coverage of excess utility costs for recipients of the state supplement to the federal Supplemental Security Income Program is eliminated. Notwithstanding the provisions of this section, the commissioner may increase the personal needs allowance component of the adult payment standard as necessary to meet federal maintenance of effort requirements.

(b) Effective July 1, 2011, the commissioner shall provide a state supplement payment for recipients of Medicaid and the federal Supplemental Security Income Program who reside in long-term care facilities sufficient to increase their personal needs allowance to sixty dollars per month. Such state supplement payment shall be made to the long-term care facility to be deposited into the personal fund account of each such recipient. For the purposes of this subsection, "long-term care facility" means a licensed chronic and convalescent nursing home, a chronic disease hospital, a rest home with nursing supervision, an intermediate care facility for [the mentally retarded] individuals with intellectual disabilities or a state humane institution.

Section 5. Section 17b-244a of the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 17b-244a. Rates for payments to residential facilities for [mentally retarded and autistic persons.] persons with intellectual disability and autism spectrum disorder. In determining the service component of the rates to be paid by the state under sections 17b-244 and 17b-246 to private facilities and facilities operated by regional education service centers that are licensed to provide residential care pursuant to section 17a-227, but not certified to participate in the Title XIX Medicaid programs as intermediate care facilities for [persons with mental retardation,] individuals with

intellectual disabilities, the Commissioner of Developmental Services shall consider for each facility the actual wage and benefit costs for services and service providers, adjusted for inflation, and said commissioner shall not establish a single fixed amount for wage and benefit costs that is applicable to all such facilities.

Section 6. Section 17b-260d of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 17b-260d. Home and community-based services waiver serving persons with acquired immune deficiency syndrome or human immunodeficiency virus. The Commissioner of Social Services shall apply for a home and community-based services waiver pursuant to Section 1915(c) of the Social Security Act that will allow the commissioner to develop and implement a program for the provision of home or community-based services, as defined in 42 CFR 440.180, to not more than fifty persons currently receiving services under the Medicaid program who (1) have tested positive for human immunodeficiency virus or have acquired immune deficiency syndrome, and (2) would remain eligible for Medicaid if admitted to a hospital, nursing facility or intermediate care facility for [the mentally retarded,] individuals with intellectual disabilities, or in the absence of the services that are requested under such waiver, would require the Medicaid covered level of care provided in such facilities.

Section 7. Section 17b-278 of the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 17b-278. (Formerly Sec. 17-134z). Home leave absences for certain medical assistance recipients. The Commissioner of Social Services shall amend the state's Medicaid plan to increase to thirty-six days per year the number of home leave absences allowed for a resident of an intermediate care facility for [the mentally retarded] individuals with intellectual disabilities who is receiving medical assistance.

Section 8. Section 17b-280 of the 2012 supplement to the general statutes as amended by Public Act 12-1 of the June 12 Special Session is repealed and the following is substituted in lieu thereof:

Sec. 17b-280. (Formerly Sec. 17-134bb). Reimbursement rate for legend drugs. Dispensing fee. Reimbursement for over-the-counter drugs and products. Dispensing fee exception. Enhanced dispensing fee. (a) The state shall reimburse for all legend drugs provided under medical assistance programs administered by the Department of Social Services at the lower of (1) the rate established by the Centers for Medicare and Medicaid Services as the federal acquisition cost, (2) the average wholesale price minus sixteen per cent, or (3) an equivalent percentage as established under the Medicaid state plan. Notwithstanding the provisions of this section, contingent upon federal approval, on and after October 1, 2012, for independent pharmacies, the state shall reimburse for such legend drugs at the lower of (A) the rate established by the Centers for Medicare and Medicaid

Services as the federal acquisition cost, (B) the average wholesale price minus fourteen per cent, or (C) an equivalent percentage as established under the Medicaid state plan. The state shall pay a professional fee of two dollars to licensed pharmacies for each prescription dispensed to a recipient of benefits under a medical assistance program administered by the Department of Social Services in accordance with federal regulations. On and after September 4, 1991, payment for legend and nonlegend drugs provided to Medicaid recipients shall be based upon the actual package size dispensed. Effective October 1, 1991, reimbursement for over-the-counter drugs for such recipients shall be limited to those over-the-counter drugs and products published in the Connecticut Formulary, or the cross reference list, issued by the commissioner. The cost of all over-the-counter drugs and products provided to residents of nursing facilities, chronic disease hospitals, and intermediate care facilities for [the mentally retarded] individuals with intellectual disabilities shall be included in the facilities' per diem rate. Notwithstanding the provisions of this subsection, no dispensing fee shall be issued for a prescription drug dispensed to a ConnPACE or Medicaid recipient who is a Medicare Part D beneficiary when the prescription drug is a Medicare Part D drug, as defined in Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(b) The Department of Social Services may provide an enhanced dispensing fee to a pharmacy enrolled in the federal Office of Pharmacy Affairs Section 340B drug discount program established pursuant to 42 USC 256b or a pharmacy under contract to provide services under said program.

(c) For purposes of this section, (1) "independent pharmacy" means a privately-owned community pharmacy that has five or fewer stores located in the state; (2) "community pharmacy" has the same meaning as in section 20-631a; and (3) "legend drug" has the same meaning as in section 20-571.

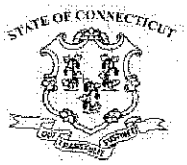
(d) The commissioner shall submit a Medicaid state plan amendment not later than October 1, 2012, to establish the independent pharmacy rate pursuant to subsection (a) of this section.

Section 9. Section 17b-340 of the 2012 supplement to the general statutes as amended by Public Act 12-1 of the June 12 Special Session is repealed and the following is substituted in lieu thereof:

Sec. 17b-340. (Formerly Sec. 17-314). Rates of payment to nursing homes, chronic disease hospitals associated with chronic and convalescent homes, rest homes with nursing supervision, residential care homes and residential facilities for [the mental retarded.] persons with intellectual disability. (a) The rates to be paid by or for persons aided or cared for by the state or any town in this state to licensed chronic and convalescent nursing homes, to chronic disease hospitals associated with chronic and convalescent nursing homes, to rest homes with nursing supervision, to licensed residential care homes, as defined by section 19a-490, and to residential facilities for[the mentally retarded] persons with intellectual disability which are licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as intermediate care facilities for [the

mentally retarded,] individuals with intellectual disabilities, for room, board and services specified in licensing regulations issued by the licensing agency shall be determined annually, except as otherwise provided in this subsection, after a public hearing, by the Commissioner of Social Services, to be effective July first of each year except as otherwise provided in this subsection. Such rates shall be determined on a basis of a reasonable payment for such necessary services, which basis shall take into account as a factor the costs of such services. Cost of such services shall include reasonable costs mandated by collective bargaining agreements with certified collective bargaining agents or other agreements between the employer and employees, provided "employees" shall not include persons employed as managers or chief administrators or required to be licensed as nursing home administrators, and compensation for services rendered by proprietors at prevailing wage rates, as determined by application of principles of accounting as prescribed by said commissioner. Cost of such services shall not include amounts paid by the facilities to employees as salary, or to attorneys or consultants as fees, where the responsibility of the employees, attorneys, or consultants is to persuade or seek to persuade the other employees of the facility to support or oppose unionization. Nothing in this subsection shall prohibit inclusion of amounts paid for legal counsel related to the negotiation of collective bargaining agreements, the settlement of grievances or normal administration of labor relations. The commissioner may, in his discretion, allow the inclusion of extraordinary and unanticipated costs of providing services which were incurred to avoid an immediate negative impact on the health and safety of patients. The commissioner may, in his discretion, based upon review of a facility's costs, direct care staff to patient ratio and any other related information, revise a facility's rate for any increases or decreases to total licensed capacity of more than ten beds or changes to its number of licensed rest home with nursing supervision beds and chronic and convalescent nursing home beds. The commissioner may so revise a facility's rate established for the fiscal year ending June 30, 1993, and thereafter for any bed increases, decreases or changes in licensure effective after October 1, 1989. Effective July 1, 1991, in facilities which have both a chronic and convalescent nursing home and a rest home with nursing supervision, the rate for the rest home with nursing supervision shall not exceed such facility's rate for its chronic and convalescent nursing home. All such facilities for which rates are determined under this subsection shall report on a fiscal year basis ending on the thirtieth day of September. Such report shall be submitted to the commissioner by the thirty-first day of December. The commissioner may reduce the rate in effect for a facility which fails to report on or before such date by an amount not to exceed ten per cent of such rate. The commissioner shall annually, on or before the fifteenth day of February, report the data contained in the reports of such facilities to the joint standing committee of the General Assembly having cognizance of matters relating to appropriations. For the cost reporting year commencing October 1, 1985, and for subsequent cost reporting years, facilities shall report the cost of using the services of any nursing pool employee by separating said cost into two categories, the portion of the cost equal to the salary of the employee for whom the nursing pool employee is substituting shall be considered a nursing cost and any cost in excess of such salary shall be further divided so that seventy-five per cent of the excess cost shall be considered an administrative or general cost and twenty-five per cent of the excess cost shall be considered a nursing cost, provided if the total nursing pool costs of a facility for any cost year are equal to or exceed fifteen per cent of the total nursing expenditures of the facility for such cost year, no portion of nursing pool costs in excess of fifteen per cent shall be classified as administrative or general costs. The commissioner, in determining such rates, shall also take into account the classification of patients or boarders

according to special care requirements or classification of the facility according to such factors as facilities and services and such other factors as he deems reasonable, including anticipated fluctuations in the cost of providing such services. The commissioner may establish a separate rate for a facility or a portion of a facility for traumatic brain injury patients who require extensive care but not acute general hospital care. Such separate rate shall reflect the special care requirements of such patients. If changes in federal or state laws, regulations or standards adopted subsequent to June 30, 1985, result in increased costs or expenditures in an amount exceeding one-half of one per cent of allowable costs for the most recent cost reporting year, the commissioner shall adjust rates and provide payment for any such increased reasonable costs or expenditures within a reasonable period of time retroactive to the date of enforcement. Nothing in this section shall be construed to require the Department of Social Services to adjust rates and provide payment for any increases in costs resulting from an inspection of a facility by the Department of Public Health. Such assistance as the commissioner requires from other state agencies or departments in determining rates shall be made available to him at his request. Payment of the rates established hereunder shall be conditioned on the establishment by such facilities of admissions procedures which conform with this section, section 19a-533 and all other applicable provisions of the law and the provision of equality of treatment to all persons in such facilities. The established rates shall be the maximum amount chargeable by such facilities for care of such beneficiaries, and the acceptance by or on behalf of any such facility of any additional compensation for care of any such beneficiary from any other person or source shall constitute the offense of aiding a beneficiary to obtain aid to which he is not entitled and shall be punishable in the same manner as is provided in subsection (b) of section 17b-97. For the fiscal year ending June 30, 1992, rates for licensed residential care homes and intermediate care facilities for [the mentally retarded] individuals with intellectual disabilities may receive an increase not to exceed the most recent annual increase in the Regional Data Resources Incorporated McGraw-Hill Health Care Costs: Consumer Price Index (all urban)-All Items. Rates for newly certified intermediate care facilities for [the mentally retarded] individuals with intellectual disabilities shall not exceed one hundred fifty per cent of the median rate of rates in effect on January 31, 1991, for intermediate care facilities for [the mentally retarded] individuals with intellectual disabilities certified prior to February 1, 1991. Notwithstanding any provision of this section, the Commissioner of Social Services may, within available appropriations, provide an interim rate increase for a licensed chronic and convalescent nursing home or a rest home with nursing supervision for rate periods no earlier than April 1, 2004, only if the commissioner determines that the increase is necessary to avoid the filing of a petition for relief under Title 11 of the United States Code; imposition of receivership pursuant to sections 19a-541 to 19a-549, inclusive; or substantial deterioration of the facility's financial condition that may be expected to adversely affect resident care and the continued operation of the facility, and the commissioner determines that the continued operation of the facility is in the best interest of the state. The commissioner shall consider any requests for interim rate increases on file with the department from March 30, 2004, and those submitted subsequently for rate periods no earlier than April 1, 2004. When reviewing a rate increase request the commissioner shall, at a minimum, consider: (1) Existing chronic and convalescent nursing home or rest home with nursing supervision utilization in the area and projected bed need; (2) physical plant long-term viability and the ability of the owner or purchaser to implement any necessary property improvements; (3) licensure and certification compliance history; (4) reasonableness of actual and projected expenses; and (5) the ability of the facility to meet wage



and benefit costs. No rate shall be increased pursuant to this subsection in excess of one hundred fifteen per cent of the median rate for the facility's peer grouping, established pursuant to subdivision (2) of subsection (f) of this section, unless recommended by the commissioner and approved by the Secretary of the Office of Policy and Management after consultation with the commissioner. Such median rates shall be published by the Department of Social Services not later than April first of each year. In the event that a facility granted an interim rate increase pursuant to this section is sold or otherwise conveyed for value to an unrelated entity less than five years after the effective date of such rate increase, the rate increase shall be deemed rescinded and the department shall recover an amount equal to the difference between payments made for all affected rate periods and payments that would have been made if the interim rate increase was not granted. The commissioner may seek recovery from payments made to any facility with common ownership. With the approval of the Secretary of the Office of Policy and Management, the commissioner may waive recovery and rescission of the interim rate for good cause shown that is not inconsistent with this section, including, but not limited to, transfers to family members that were made for no value. The commissioner shall provide written quarterly reports to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies and to the select committee of the General Assembly having cognizance of matters relating to aging, that identify each facility requesting an interim rate increase, the amount of the requested rate increase for each facility, the action taken by the commissioner and the secretary pursuant to this subsection, and estimates of the additional cost to the state for each approved interim rate increase. Nothing in this subsection shall prohibit the commissioner from increasing the rate of a licensed chronic and convalescent nursing home or a rest home with nursing supervision for allowable costs associated with facility capital improvements or increasing the rate in case of a sale of a licensed chronic and convalescent nursing home or a rest home with nursing supervision, pursuant to subdivision (15) of subsection (f) of this section, if receivership has been imposed on such home.

(b) The Commissioner of Social Services shall adopt regulations in accordance with the provisions of chapter 54 to specify other allowable services. For purposes of this section, other allowable services means those services required by any medical assistance beneficiary residing in such home or hospital which are not already covered in the rate set by the commissioner in accordance with the provisions of subsection (a) of this section.

(c) No facility subject to the requirements of this section shall accept payment in excess of the rate set by the commissioner pursuant to subsection (a) of this section for any medical assistance patient from this or any other state. No facility shall accept payment in excess of the reasonable and necessary costs of other allowable services as specified by the commissioner pursuant to the regulations adopted under subsection (b) of this section for any public assistance patient from this or any other state. Notwithstanding the provisions of this subsection, the commissioner may authorize a facility to accept payment in excess of the rate paid for a medical assistance patient in this state for a patient who receives medical assistance from another state.

(d) In any instance where the Commissioner of Social Services finds that a facility subject to the requirements of this section is accepting payment for a medical assistance beneficiary in violation of

subsection (c) of this section, the commissioner shall proceed to recover through the rate set for the facility any sum in excess of the stipulated per diem and other allowable costs, as provided for in regulations adopted pursuant to subsections (a) and (b) of this section. The commissioner shall make the recovery prospectively at the time of the next annual rate redetermination.

(e) Except as provided in this subsection, the provisions of subsections (c) and (d) of this section shall not apply to any facility subject to the requirements of this section, which on October 1, 1981, (1) was accepting payments from the commissioner in accordance with the provisions of subsection (a) of this section, (2) was accepting medical assistance payments from another state for at least twenty per cent of its patients, and (3) had not notified the commissioner of any intent to terminate its provider agreement, in accordance with section 17b-271, provided no patient residing in any such facility on May 22, 1984, shall be removed from such facility for purposes of meeting the requirements of this subsection. If the commissioner finds that the number of beds available to medical assistance patients from this state in any such facility is less than fifteen per cent the provisions of subsections (c) and (d) of this section shall apply to that number of beds which is less than said percentage.

(f) For the fiscal year ending June 30, 1992, the rates paid by or for persons aided or cared for by the state or any town in this state to facilities for room, board and services specified in licensing regulations issued by the licensing agency, except intermediate care facilities for [the mentally retarded] individuals with intellectual disabilities and residential care homes, shall be based on the cost year ending September 30, 1989. For the fiscal years ending June 30, 1993, and June 30, 1994, such rates shall be based on the cost year ending September 30, 1990. Such rates shall be determined by the Commissioner of Social Services in accordance with this section and the regulations of Connecticut state agencies promulgated by the commissioner and in effect on April 1, 1991, except that:

(1) Allowable costs shall be divided into the following five cost components: Direct costs, which shall include salaries for nursing personnel, related fringe benefits and nursing pool costs; indirect costs, which shall include professional fees, dietary expenses, housekeeping expenses, laundry expenses, supplies related to patient care, salaries for indirect care personnel and related fringe benefits; fair rent, which shall be defined in accordance with subsection (f) of section 17-311-52 of the regulations of Connecticut state agencies; capital-related costs, which shall include property taxes, insurance expenses, equipment leases and equipment depreciation; and administrative and general costs, which shall include maintenance and operation of plant expenses, salaries for administrative and maintenance personnel and related fringe benefits. The commissioner may provide a rate adjustment for nonemergency transportation services required by nursing facility residents. Such adjustment shall be a fixed amount determined annually by the commissioner based upon a review of costs and other associated information. Allowable costs shall not include costs for ancillary services payable under Part B of the Medicare program.

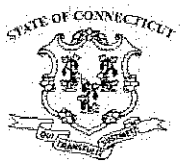
(2) Two geographic peer groupings of facilities shall be established for each level of care, as defined by the Department of Social Services for the determination of rates, for the purpose of determining

allowable direct costs. One peer grouping shall be comprised of those facilities located in Fairfield County. The other peer grouping shall be comprised of facilities located in all other counties.

(3) For the fiscal year ending June 30, 1992, per diem maximum allowable costs for each cost component shall be as follows: For direct costs, the maximum shall be equal to one hundred forty per cent of the median allowable cost of that peer grouping; for indirect costs, the maximum shall be equal to one hundred thirty per cent of the state-wide median allowable cost; for fair rent, the amount shall be calculated utilizing the amount approved by the Office of Health Care Access pursuant to section 19a-638; for capital-related costs, there shall be no maximum; and for administrative and general costs, the maximum shall be equal to one hundred twenty-five per cent of the state-wide median allowable cost. For the fiscal year ending June 30, 1993, per diem maximum allowable costs for each cost component shall be as follows: For direct costs, the maximum shall be equal to one hundred forty per cent of the median allowable cost of that peer grouping; for indirect costs, the maximum shall be equal to one hundred twenty-five per cent of the state-wide median allowable cost; for fair rent, the amount shall be calculated utilizing the amount approved by the Office of Health Care Access pursuant to section 19a-638; for capital-related costs, there shall be no maximum; and for administrative and general costs the maximum shall be equal to one hundred fifteen per cent of the state-wide median allowable cost. For the fiscal year ending June 30, 1994, per diem maximum allowable costs for each cost component shall be as follows: For direct costs, the maximum shall be equal to one hundred thirty-five per cent of the median allowable cost of that peer grouping; for indirect costs, the maximum shall be equal to one hundred twenty per cent of the state-wide median allowable cost; for fair rent, the amount shall be calculated utilizing the amount approved by the Office of Health Care Access pursuant to section 19a-638; for capital-related costs, there shall be no maximum; and for administrative and general costs the maximum shall be equal to one hundred ten per cent of the state-wide median allowable cost. For the fiscal year ending June 30, 1995, per diem maximum allowable costs for each cost component shall be as follows: For direct costs, the maximum shall be equal to one hundred thirty-five per cent of the median allowable cost of that peer grouping; for indirect costs, the maximum shall be equal to one hundred twenty per cent of the state-wide median allowable cost; for fair rent, the amount shall be calculated utilizing the amount approved by the Office of Health Care Access pursuant to section 19a-638; for capital-related costs, there shall be no maximum; and for administrative and general costs the maximum shall be equal to one hundred five per cent of the state-wide median allowable cost. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, except for the fiscal years ending June 30, 2000, and June 30, 2001, for facilities with an interim rate in one or both periods, per diem maximum allowable costs for each cost component shall be as follows: For direct costs, the maximum shall be equal to one hundred thirty-five per cent of the median allowable cost of that peer grouping; for indirect costs, the maximum shall be equal to one hundred fifteen per cent of the state-wide median allowable cost; for fair rent, the amount shall be calculated utilizing the amount approved pursuant to section 19a-638; for capital-related costs, there shall be no maximum; and for administrative and general costs the maximum shall be equal to the state-wide median allowable cost. For the fiscal years ending June 30, 2000, and June 30, 2001, for facilities with an interim rate in one or both periods, per diem maximum allowable costs for each cost component shall be as follows: For direct costs, the maximum shall be equal to one hundred forty-five per cent of the median allowable cost of that peer grouping; for indirect costs, the maximum shall be equal to one

hundred twenty-five per cent of the state-wide median allowable cost; for fair rent, the amount shall be calculated utilizing the amount approved pursuant to section 19a-638; for capital-related costs, there shall be no maximum; and for administrative and general costs, the maximum shall be equal to the state-wide median allowable cost and such medians shall be based upon the same cost year used to set rates for facilities with prospective rates. Costs in excess of the maximum amounts established under this subsection shall not be recognized as allowable costs, except that the Commissioner of Social Services (A) may allow costs in excess of maximum amounts for any facility with patient days covered by Medicare, including days requiring coinsurance, in excess of twelve per cent of annual patient days which also has patient days covered by Medicaid in excess of fifty per cent of annual patient days; (B) may establish a pilot program whereby costs in excess of maximum amounts shall be allowed for beds in a nursing home which has a managed care program and is affiliated with a hospital licensed under chapter 368v; and (C) may establish rates whereby allowable costs may exceed such maximum amounts for beds approved on or after July 1, 1991, which are restricted to use by patients with acquired immune deficiency syndrome or traumatic brain injury.

(4) For the fiscal year ending June 30, 1992, (A) no facility shall receive a rate that is less than the rate it received for the rate year ending June 30, 1991; (B) no facility whose rate, if determined pursuant to this subsection, would exceed one hundred twenty per cent of the state-wide median rate, as determined pursuant to this subsection, shall receive a rate which is five and one-half per cent more than the rate it received for the rate year ending June 30, 1991; and (C) no facility whose rate, if determined pursuant to this subsection, would be less than one hundred twenty per cent of the state-wide median rate, as determined pursuant to this subsection, shall receive a rate which is six and one-half per cent more than the rate it received for the rate year ending June 30, 1991. For the fiscal year ending June 30, 1993, no facility shall receive a rate that is less than the rate it received for the rate year ending June 30, 1992, or six per cent more than the rate it received for the rate year ending June 30, 1992. For the fiscal year ending June 30, 1994, no facility shall receive a rate that is less than the rate it received for the rate year ending June 30, 1993, or six per cent more than the rate it received for the rate year ending June 30, 1993. For the fiscal year ending June 30, 1995, no facility shall receive a rate that is more than five per cent less than the rate it received for the rate year ending June 30, 1994, or six per cent more than the rate it received for the rate year ending June 30, 1994. For the fiscal years ending June 30, 1996, and June 30, 1997, no facility shall receive a rate that is more than three per cent more than the rate it received for the prior rate year. For the fiscal year ending June 30, 1998, a facility shall receive a rate increase that is not more than two per cent more than the rate that the facility received in the prior year. For the fiscal year ending June 30, 1999, a facility shall receive a rate increase that is not more than three per cent more than the rate that the facility received in the prior year and that is not less than one per cent more than the rate that the facility received in the prior year, exclusive of rate increases associated with a wage, benefit and staffing enhancement rate adjustment added for the period from April 1, 1999, to June 30, 1999, inclusive. For the fiscal year ending June 30, 2000, each facility, except a facility with an interim rate or replaced interim rate for the fiscal year ending June 30, 1999, and a facility having a certificate of need or other agreement specifying rate adjustments for the fiscal year ending June 30, 2000, shall receive a rate increase equal to one per cent applied to the rate the facility received for the fiscal year ending June 30, 1999, exclusive of the facility's wage, benefit and staffing enhancement rate adjustment. For the fiscal year ending June 30, 2000, no facility with an interim



rate, replaced interim rate or scheduled rate adjustment specified in a certificate of need or other agreement for the fiscal year ending June 30, 2000, shall receive a rate increase that is more than one per cent more than the rate the facility received in the fiscal year ending June 30, 1999. For the fiscal year ending June 30, 2001, each facility, except a facility with an interim rate or replaced interim rate for the fiscal year ending June 30, 2000, and a facility having a certificate of need or other agreement specifying rate adjustments for the fiscal year ending June 30, 2001, shall receive a rate increase equal to two per cent applied to the rate the facility received for the fiscal year ending June 30, 2000, subject to verification of wage enhancement adjustments pursuant to subdivision (14) of this subsection. For the fiscal year ending June 30, 2001, no facility with an interim rate, replaced interim rate or scheduled rate adjustment specified in a certificate of need or other agreement for the fiscal year ending June 30, 2001, shall receive a rate increase that is more than two per cent more than the rate the facility received for the fiscal year ending June 30, 2000. For the fiscal year ending June 30, 2002, each facility shall receive a rate that is two and one-half per cent more than the rate the facility received in the prior fiscal year. For the fiscal year ending June 30, 2003, each facility shall receive a rate that is two per cent more than the rate the facility received in the prior fiscal year, except that such increase shall be effective January 1, 2003, and such facility rate in effect for the fiscal year ending June 30, 2002, shall be paid for services provided until December 31, 2002, except any facility that would have been issued a lower rate effective July 1, 2002, than for the fiscal year ending June 30, 2002, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2002, and have such rate increased two per cent effective June 1, 2003. For the fiscal year ending June 30, 2004, rates in effect for the period ending June 30, 2003, shall remain in effect, except any facility that would have been issued a lower rate effective July 1, 2003, than for the fiscal year ending June 30, 2003, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2003. For the fiscal year ending June 30, 2005, rates in effect for the period ending June 30, 2004, shall remain in effect until December 31, 2004, except any facility that would have been issued a lower rate effective July 1, 2004, than for the fiscal year ending June 30, 2004, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2004. Effective January 1, 2005, each facility shall receive a rate that is one per cent greater than the rate in effect December 31, 2004. Effective upon receipt of all the necessary federal approvals to secure federal financial participation matching funds associated with the rate increase provided in this subdivision, but in no event earlier than July 1, 2005, and provided the user fee imposed under section 17b-320 is required to be collected, for the fiscal year ending June 30, 2006, the department shall compute the rate for each facility based upon its 2003 cost report filing or a subsequent cost year filing for facilities having an interim rate for the period ending June 30, 2005, as provided under section 17-311-55 of the regulations of Connecticut state agencies. For each facility not having an interim rate for the period ending June 30, 2005, the rate for the period ending June 30, 2006, shall be determined beginning with the higher of the computed rate based upon its 2003 cost report filing or the rate in effect for the period ending June 30, 2005. Such rate shall then be increased by eleven dollars and eighty cents per day except that in no event shall the rate for the period ending June 30, 2006, be thirty-two dollars more than the rate in effect for the period ending June 30, 2005, and for any facility with a rate below one hundred ninety-five dollars per day for the period ending June 30, 2005, such rate for the period ending June 30, 2006, shall not be greater than two hundred seventeen dollars and forty-three cents per day and for any facility with a rate equal to or greater than one hundred ninety-five dollars per day for the period ending June 30,

2005, such rate for the period ending June 30, 2006, shall not exceed the rate in effect for the period ending June 30, 2005, increased by eleven and one-half per cent. For each facility with an interim rate for the period ending June 30, 2005, the interim replacement rate for the period ending June 30, 2006, shall not exceed the rate in effect for the period ending June 30, 2005, increased by eleven dollars and eighty cents per day plus the per day cost of the user fee payments made pursuant to section 17b-320 divided by annual resident service days, except for any facility with an interim rate below one hundred ninety-five dollars per day for the period ending June 30, 2005, the interim replacement rate for the period ending June 30, 2006, shall not be greater than two hundred seventeen dollars and forty-three cents per day and for any facility with an interim rate equal to or greater than one hundred ninety-five dollars per day for the period ending June 30, 2005, the interim replacement rate for the period ending June 30, 2006, shall not exceed the rate in effect for the period ending June 30, 2005, increased by eleven and one-half per cent. Such July 1, 2005, rate adjustments shall remain in effect unless (i) the federal financial participation matching funds associated with the rate increase are no longer available; or (ii) the user fee created pursuant to section 17b-320 is not in effect. For the fiscal year ending June 30, 2007, each facility shall receive a rate that is three per cent greater than the rate in effect for the period ending June 30, 2006, except any facility that would have been issued a lower rate effective July 1, 2006, than for the rate period ending June 30, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2006. For the fiscal year ending June 30, 2008, each facility shall receive a rate that is two and nine-tenths per cent greater than the rate in effect for the period ending June 30, 2007, except any facility that would have been issued a lower rate effective July 1, 2007, than for the rate period ending June 30, 2007, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2007. For the fiscal year ending June 30, 2009, rates in effect for the period ending June 30, 2008, shall remain in effect until June 30, 2009, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2009, due to interim rate status or agreement with the department shall be issued such lower rate. For the fiscal years ending June 30, 2010, and June 30, 2011, rates in effect for the period ending June 30, 2009, shall remain in effect until June 30, 2011, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2010, or the fiscal year ending June 30, 2011, due to interim rate status or agreement with the department, shall be issued such lower rate. For the fiscal years ending June 30, 2012, and June 30, 2013, rates in effect for the period ending June 30, 2011, shall remain in effect until June 30, 2013, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2012, or the fiscal year ending June 30, 2013, due to interim rate status or agreement with the department, shall be issued such lower rate. The Commissioner of Social Services shall add fair rent increases to any other rate increases established pursuant to this subdivision for a facility which has undergone a material change in circumstances related to fair rent, except for the fiscal years ending June 30, 2010, June 30, 2011, and June 30, 2012, such fair rent increases shall only be provided to facilities with an approved certificate of need pursuant to section 17b-352, 17b-353, 17b-354 or 17b-355. For the fiscal year ending June 30, 2013, the commissioner may, within available appropriations, provide pro rata fair rent increases for facilities which have undergone a material change in circumstances related to fair rent additions placed in service in cost report years ending September 30, 2008, to September 30, 2011, inclusive, and not otherwise included in rates issued. For the fiscal year ending June 30, 2013, the commissioner shall add fair rent increases associated with an approved certificate of need pursuant to section 17b-352, 17b-353,

17b-354 or 17b-355. Interim rates may take into account reasonable costs incurred by a facility, including wages and benefits. Notwithstanding the provisions of this section, the Commissioner of Social Services may, within available appropriations, increase rates issued to licensed chronic and convalescent nursing homes and licensed rest homes with nursing supervision.

(5) For the purpose of determining allowable fair rent, a facility with allowable fair rent less than the twenty-fifth percentile of the state-wide allowable fair rent shall be reimbursed as having allowable fair rent equal to the twenty-fifth percentile of the state-wide allowable fair rent, provided for the fiscal years ending June 30, 1996, and June 30, 1997, the reimbursement may not exceed the twenty-fifth percentile of the state-wide allowable fair rent for the fiscal year ending June 30, 1995. On and after July 1, 1998, the Commissioner of Social Services may allow minimum fair rent as the basis upon which reimbursement associated with improvements to real property is added. Beginning with the fiscal year ending June 30, 1996, any facility with a rate of return on real property other than land in excess of eleven per cent shall have such allowance revised to eleven per cent. Any facility or its related realty affiliate which finances or refinances debt through bonds issued by the State of Connecticut Health and Education Facilities Authority shall report the terms and conditions of such financing or refinancing to the Commissioner of Social Services within thirty days of completing such financing or refinancing. The Commissioner of Social Services may revise the facility's fair rent component of its rate to reflect any financial benefit the facility or its related realty affiliate received as a result of such financing or refinancing, including but not limited to, reductions in the amount of debt service payments or period of debt repayment. The commissioner shall allow actual debt service costs for bonds issued by the State of Connecticut Health and Educational Facilities Authority if such costs do not exceed property costs allowed pursuant to subsection (f) of section 17-311-52 of the regulations of Connecticut state agencies, provided the commissioner may allow higher debt service costs for such bonds for good cause. For facilities which first open on or after October 1, 1992, the commissioner shall determine allowable fair rent for real property other than land based on the rate of return for the cost year in which such bonds were issued. The financial benefit resulting from a facility financing or refinancing debt through such bonds shall be shared between the state and the facility to an extent determined by the commissioner on a case-by-case basis and shall be reflected in an adjustment to the facility's allowable fair rent.

(6) A facility shall receive cost efficiency adjustments for indirect costs and for administrative and general costs if such costs are below the state-wide median costs. The cost efficiency adjustments shall equal twenty-five per cent of the difference between allowable reported costs and the applicable median allowable cost established pursuant to this subdivision.

(7) For the fiscal year ending June 30, 1992, allowable operating costs, excluding fair rent, shall be inflated using the Regional Data Resources Incorporated McGraw-Hill Health Care Costs: Consumer Price Index (all urban)-All Items minus one and one-half per cent. For the fiscal year ending June 30, 1993, allowable operating costs, excluding fair rent, shall be inflated using the Regional Data Resources Incorporated McGraw-Hill Health Care Costs: Consumer Price Index (all urban)-All Items minus one and three-quarters per cent. For the fiscal years ending June 30, 1994, and June 30, 1995, allowable operating costs, excluding fair rent, shall be inflated using the Regional Data Resources Incorporated McGraw-Hill Health Care Costs: Consumer Price Index (all urban)-All

Items minus two per cent. For the fiscal year ending June 30, 1996, allowable operating costs, excluding fair rent, shall be inflated using the Regional Data Resources Incorporated McGraw-Hill Health Care Costs: Consumer Price Index (all urban)-All Items minus two and one-half per cent. For the fiscal year ending June 30, 1997, allowable operating costs, excluding fair rent, shall be inflated using the Regional Data Resources Incorporated McGraw-Hill Health Care Costs: Consumer Price Index (all urban)-All Items minus three and one-half per cent. For the fiscal year ending June 30, 1992, and any succeeding fiscal year, allowable fair rent shall be those reported in the annual report of long-term care facilities for the cost year ending the immediately preceding September thirtieth. The inflation index to be used pursuant to this subsection shall be computed to reflect inflation between the midpoint of the cost year through the midpoint of the rate year. The Department of Social Services shall study methods of reimbursement for fair rent and shall report its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to human services on or before January 15, 1993.

(8) On and after July 1, 1994, costs shall be rebased no more frequently than every two years and no less frequently than every four years, as determined by the commissioner. The commissioner shall determine whether and to what extent a change in ownership of a facility shall occasion the rebasing of the facility's costs.

(9) The method of establishing rates for new facilities shall be determined by the commissioner in accordance with the provisions of this subsection.

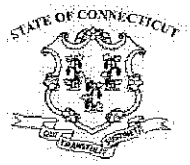
(10) Rates determined under this section shall comply with federal laws and regulations.

(11) Notwithstanding the provisions of this subsection, interim rates issued for facilities on and after July 1, 1991, shall be subject to applicable fiscal year cost component limitations established pursuant to subdivision (3) of this subsection.

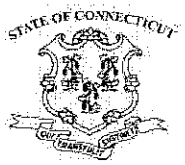
(12) A chronic and convalescent nursing home having an ownership affiliation with and operated at the same location as a chronic disease hospital may request that the commissioner approve an exception to applicable rate-setting provisions for chronic and convalescent nursing homes and establish a rate for the fiscal years ending June 30, 1992, and June 30, 1993, in accordance with regulations in effect June 30, 1991. Any such rate shall not exceed one hundred sixty-five per cent of the median rate established for chronic and convalescent nursing homes established under this section for the applicable fiscal year.

(13) For the fiscal year ending June 30, 1994, and any succeeding fiscal year, for purposes of computing minimum allowable patient days, utilization of a facility's certified beds shall be determined at a minimum of ninety-five per cent of capacity, except for new facilities and facilities which are certified for additional beds which may be permitted a lower occupancy rate for the first three months of operation after the effective date of licensure.

(14) The Commissioner of Social Services shall adjust facility rates from April 1, 1999, to June 30, 1999, inclusive, by a per diem amount representing each facility's allocation of funds appropriated



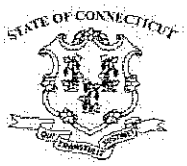
for the purpose of wage, benefit and staffing enhancement. A facility's per diem allocation of such funding shall be computed as follows: (A) The facility's direct and indirect component salary, wage, nursing pool and allocated fringe benefit costs as filed for the 1998 cost report period deemed allowable in accordance with this section and applicable regulations without application of cost component maximums specified in subdivision (3) of this subsection shall be totalled; (B) such total shall be multiplied by the facility's Medicaid utilization based on the 1998 cost report; (C) the resulting amount for the facility shall be divided by the sum of the calculations specified in subparagraphs (A) and (B) of this subdivision for all facilities to determine the facility's percentage share of appropriated wage, benefit and staffing enhancement funding; (D) the facility's percentage share shall be multiplied by the amount of appropriated wage, benefit and staffing enhancement funding to determine the facility's allocated amount; and (E) such allocated amount shall be divided by the number of days of care paid for by Medicaid on an annual basis including days for reserved beds specified in the 1998 cost report to determine the per diem wage and benefit rate adjustment amount. The commissioner may adjust a facility's reported 1998 cost and utilization data for the purposes of determining a facility's share of wage, benefit and staffing enhancement funding when reported 1998 information is not substantially representative of estimated cost and utilization data for the fiscal year ending June 30, 2000, due to special circumstances during the 1998 cost report period including change of ownership with a part year cost filing or reductions in facility capacity due to facility renovation projects. Upon completion of the calculation of the allocation of wage, benefit and staffing enhancement funding, the commissioner shall not adjust the allocations due to revisions submitted to previously filed 1998 annual cost reports. In the event that a facility's rate for the fiscal year ending June 30, 1999, is an interim rate or the rate includes an increase adjustment due to a rate request to the commissioner or other reasons, the commissioner may reduce or withhold the per diem wage, benefit and staffing enhancement allocation computed for the facility. Any enhancement allocations not applied to facility rates shall not be reallocated to other facilities and such unallocated amounts shall be available for the costs associated with interim rates and other Medicaid expenditures. The wage, benefit and staffing enhancement per diem adjustment for the period from April 1, 1999, to June 30, 1999, inclusive, shall also be applied to rates for the fiscal years ending June 30, 2000, and June 30, 2001, except that the commissioner may increase or decrease the adjustment to account for changes in facility capacity or operations. Any facility accepting a rate adjustment for wage, benefit and staffing enhancements shall apply payments made as a result of such rate adjustment for increased allowable employee wage rates and benefits and additional direct and indirect component staffing. Adjustment funding shall not be applied to wage and salary increases provided to the administrator, assistant administrator, owners or related party employees. Enhancement payments may be applied to increases in costs associated with staffing purchased from staffing agencies provided such costs are deemed necessary and reasonable by the commissioner. The commissioner shall compare expenditures for wages, benefits and staffing for the 1998 cost report period to such expenditures in the 1999, 2000 and 2001 cost report periods to verify whether a facility has applied additional payments to specified enhancements. In the event that the commissioner determines that a facility did not apply additional payments to specified enhancements, the commissioner shall recover such amounts from the facility through rate adjustments or other means. The commissioner may require facilities to file cost reporting forms, in addition to the annual cost report, as may be necessary, to verify the appropriate application of wage, benefit and staffing enhancement rate adjustment payments. For the purposes of this subdivision,



"Medicaid utilization" means the number of days of care paid for by Medicaid on an annual basis including days for reserved beds as a percentage of total resident days.

(15) The interim rate established to become effective upon sale of any licensed chronic and convalescent home or rest home with nursing supervision for which a receivership has been imposed pursuant to sections 19a-541 to 19a-549, inclusive, shall not exceed the rate in effect for the facility at the time of the imposition of the receivership, subject to any annual increases permitted by this section; provided the Commissioner of Social Services may, in the commissioner's discretion, and after consultation with the receiver, establish an increased rate for the facility if the commissioner with approval of the Secretary of the Office of Policy and Management determines that such higher rate is needed to keep the facility open and to ensure the health, safety and welfare of the residents at such facility.

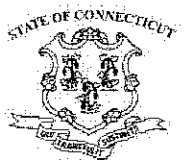
(g) For the fiscal year ending June 30, 1993, any intermediate care facility for [the mentally retarded] individuals with intellectual disabilities with an operating cost component of its rate in excess of one hundred forty per cent of the median of operating cost components of rates in effect January 1, 1992, shall not receive an operating cost component increase. For the fiscal year ending June 30, 1993, any intermediate care facility for [the mentally retarded] individuals with intellectual disabilities with an operating cost component of its rate that is less than one hundred forty per cent of the median of operating cost components of rates in effect January 1, 1992, shall have an allowance for real wage growth equal to thirty per cent of the increase determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, provided such operating cost component shall not exceed one hundred forty per cent of the median of operating cost components in effect January 1, 1992. Any facility with real property other than land placed in service prior to October 1, 1991, shall, for the fiscal year ending June 30, 1995, receive a rate of return on real property equal to the average of the rates of return applied to real property other than land placed in service for the five years preceding October 1, 1993. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the rate of return on real property for property items shall be revised every five years. The commissioner shall, upon submission of a request, allow actual debt service, comprised of principal and interest, in excess of property costs allowed pursuant to section 17-311-52 of the regulations of Connecticut state agencies, provided such debt service terms and amounts are reasonable in relation to the useful life and the base value of the property. For the fiscal year ending June 30, 1995, and any succeeding fiscal year, the inflation adjustment made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies shall not be applied to real property costs. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the allowance for real wage growth, as determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, shall not be applied. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, no rate shall exceed three hundred seventy-five dollars per day unless the commissioner, in consultation with the Commissioner of Developmental Services, determines after a review of program and management costs, that a rate in excess of this amount is necessary for care and treatment of facility residents. For the fiscal year ending June 30, 2002, rate period, the Commissioner of Social Services shall increase the inflation adjustment for rates made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies to update allowable fiscal year 2000 costs to include a three and one-



half per cent inflation factor. For the fiscal year ending June 30, 2003, rate period, the commissioner shall increase the inflation adjustment for rates made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies to update allowable fiscal year 2001 costs to include a one and one-half per cent inflation factor, except that such increase shall be effective November 1, 2002, and such facility rate in effect for the fiscal year ending June 30, 2002, shall be paid for services provided until October 31, 2002, except any facility that would have been issued a lower rate effective July 1, 2002, than for the fiscal year ending June 30, 2002, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2002, and have such rate updated effective November 1, 2002, in accordance with applicable statutes and regulations. For the fiscal year ending June 30, 2004, rates in effect for the period ending June 30, 2003, shall remain in effect, except any facility that would have been issued a lower rate effective July 1, 2003, than for the fiscal year ending June 30, 2003, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2003. For the fiscal year ending June 30, 2005, rates in effect for the period ending June 30, 2004, shall remain in effect until September 30, 2004. Effective October 1, 2004, each facility shall receive a rate that is five per cent greater than the rate in effect September 30, 2004. Effective upon receipt of all the necessary federal approvals to secure federal financial participation matching funds associated with the rate increase provided in subdivision (4) of subsection (f) of this section, but in no event earlier than October 1, 2005, and provided the user fee imposed under section 17b-320 is required to be collected, each facility shall receive a rate that is four per cent more than the rate the facility received in the prior fiscal year, except any facility that would have been issued a lower rate effective October 1, 2005, than for the fiscal year ending June 30, 2005, due to interim rate status or agreement with the department, shall be issued such lower rate effective October 1, 2005. Such rate increase shall remain in effect unless: (1) The federal financial participation matching funds associated with the rate increase are no longer available; or (2) the user fee created pursuant to section 17b-320 is not in effect. For the fiscal year ending June 30, 2007, rates in effect for the period ending June 30, 2006, shall remain in effect until September 30, 2006, except any facility that would have been issued a lower rate effective July 1, 2006, than for the fiscal year ending June 30, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2006. Effective October 1, 2006, no facility shall receive a rate that is more than three per cent greater than the rate in effect for the facility on September 30, 2006, except any facility that would have been issued a lower rate effective October 1, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective October 1, 2006. For the fiscal year ending June 30, 2008, each facility shall receive a rate that is two and nine-tenths per cent greater than the rate in effect for the period ending June 30, 2007, except any facility that would have been issued a lower rate effective July 1, 2007, than for the rate period ending June 30, 2007, due to interim rate status, or agreement with the department, shall be issued such lower rate effective July 1, 2007. For the fiscal year ending June 30, 2009, rates in effect for the period ending June 30, 2008, shall remain in effect until June 30, 2009, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2009, due to interim rate status or agreement with the department, shall be issued such lower rate. For the fiscal years ending June 30, 2010, and June 30, 2011, rates in effect for the period ending June 30, 2009, shall remain in effect until June 30, 2011, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2010, or the fiscal year ending June 30, 2011, due to interim rate status or agreement with the department, shall be issued

such lower rate. For the fiscal year ending June 30, 2012, rates in effect for the period ending June 30, 2011, shall remain in effect until June 30, 2012, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2012, due to interim rate status or agreement with the department, shall be issued such lower rate. For the fiscal year ending June 30, 2013, any facility that has a significant decrease in land and building costs shall receive a reduced rate to reflect such decrease in land and building costs. For the fiscal years ending June 30, 2012, and June 30, 2013, the Commissioner of Social Services may provide fair rent increases to any facility that has undergone a material change in circumstances related to fair rent and has an approved certificate of need pursuant to section 17b-352, 17b-353, 17b-354 or 17b-355. Notwithstanding the provisions of this section, the Commissioner of Social Services may, within available appropriations, increase rates issued to intermediate care facilities for [the mentally retarded.] individuals with intellectual disabilities.

(h) (1) For the fiscal year ending June 30, 1993, any residential care home with an operating cost component of its rate in excess of one hundred thirty per cent of the median of operating cost components of rates in effect January 1, 1992, shall not receive an operating cost component increase. For the fiscal year ending June 30, 1993, any residential care home with an operating cost component of its rate that is less than one hundred thirty per cent of the median of operating cost components of rates in effect January 1, 1992, shall have an allowance for real wage growth equal to sixty-five per cent of the increase determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, provided such operating cost component shall not exceed one hundred thirty per cent of the median of operating cost components in effect January 1, 1992. Beginning with the fiscal year ending June 30, 1993, for the purpose of determining allowable fair rent, a residential care home with allowable fair rent less than the twenty-fifth percentile of the state-wide allowable fair rent shall be reimbursed as having allowable fair rent equal to the twenty-fifth percentile of the state-wide allowable fair rent. Beginning with the fiscal year ending June 30, 1997, a residential care home with allowable fair rent less than three dollars and ten cents per day shall be reimbursed as having allowable fair rent equal to three dollars and ten cents per day. Property additions placed in service during the cost year ending September 30, 1996, or any succeeding cost year shall receive a fair rent allowance for such additions as an addition to three dollars and ten cents per day if the fair rent for the facility for property placed in service prior to September 30, 1995, is less than or equal to three dollars and ten cents per day. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the allowance for real wage growth, as determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, shall not be applied. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the inflation adjustment made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies shall not be applied to real property costs. Beginning with the fiscal year ending June 30, 1997, minimum allowable patient days for rate computation purposes for a residential care home with twenty-five beds or less shall be eighty-five per cent of licensed capacity. Beginning with the fiscal year ending June 30, 2002, for the purposes of determining the allowable salary of an administrator of a residential care home with sixty beds or less the department shall revise the allowable base salary to thirty-seven thousand dollars to be annually inflated thereafter in accordance with section 17-311-52 of the regulations of Connecticut state agencies. The rates for the fiscal year ending June 30, 2002, shall be based upon the increased allowable salary of an administrator, regardless of whether such amount was expended in the 2000



cost report period upon which the rates are based. Beginning with the fiscal year ending June 30, 2000, and until the fiscal year ending June 30, 2009, inclusive, the inflation adjustment for rates made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies shall be increased by two per cent, and beginning with the fiscal year ending June 30, 2002, the inflation adjustment for rates made in accordance with subsection (c) of said section shall be increased by one per cent. Beginning with the fiscal year ending June 30, 1999, for the purpose of determining the allowable salary of a related party, the department shall revise the maximum salary to twenty-seven thousand eight hundred fifty-six dollars to be annually inflated thereafter in accordance with section 17-311-52 of the regulations of Connecticut state agencies and beginning with the fiscal year ending June 30, 2001, such allowable salary shall be computed on an hourly basis and the maximum number of hours allowed for a related party other than the proprietor shall be increased from forty hours to forty-eight hours per work week. For the fiscal year ending June 30, 2005, each facility shall receive a rate that is two and one-quarter per cent more than the rate the facility received in the prior fiscal year, except any facility that would have been issued a lower rate effective July 1, 2004, than for the fiscal year ending June 30, 2004, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2004. Effective upon receipt of all the necessary federal approvals to secure federal financial participation matching funds associated with the rate increase provided in subdivision (4) of subsection (f) of this section, but in no event earlier than October 1, 2005, and provided the user fee imposed under section 17b-320 is required to be collected, each facility shall receive a rate that is determined in accordance with applicable law and subject to appropriations, except any facility that would have been issued a lower rate effective October 1, 2005, than for the fiscal year ending June 30, 2005, due to interim rate status or agreement with the department, shall be issued such lower rate effective October 1, 2005. Such rate increase shall remain in effect unless: (A) The federal financial participation matching funds associated with the rate increase are no longer available; or (B) the user fee created pursuant to section 17b-320 is not in effect. For the fiscal year ending June 30, 2007, rates in effect for the period ending June 30, 2006, shall remain in effect until September 30, 2006, except any facility that would have been issued a lower rate effective July 1, 2006, than for the fiscal year ending June 30, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2006. Effective October 1, 2006, no facility shall receive a rate that is more than four per cent greater than the rate in effect for the facility on September 30, 2006, except for any facility that would have been issued a lower rate effective October 1, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective October 1, 2006. For the fiscal years ending June 30, 2010, and June 30, 2011, rates in effect for the period ending June 30, 2009, shall remain in effect until June 30, 2011, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2010, or the fiscal year ending June 30, 2011, due to interim rate status or agreement with the department, shall be issued such lower rate, except (i) any facility that would have been issued a lower rate for the fiscal year ending June 30, 2010, or the fiscal year ending June 30, 2011, due to interim rate status or agreement with the Commissioner of Social Services shall be issued such lower rate; and (ii) the commissioner may increase a facility's rate for reasonable costs associated with such facility's compliance with the provisions of section 19a-495a concerning the administration of medication by unlicensed personnel. For the fiscal year ending June 30, 2012, rates in effect for the period ending June 30, 2011, shall remain in effect until June 30, 2012, except that (I) any facility that would have been issued a lower rate for the fiscal year

ending June 30, 2012, due to interim rate status or agreement with the Commissioner of Social Services shall be issued such lower rate; and (II) the commissioner may increase a facility's rate for reasonable costs associated with such facility's compliance with the provisions of section 19a-495a concerning the administration of medication by unlicensed personnel. For the fiscal year ending June 30, 2013, the Commissioner of Social Services may, within available appropriations, provide a rate increase to a residential care home. Any facility that would have been issued a lower rate for the fiscal year ending June 30, 2013, due to interim rate status or agreement with the Commissioner of Social Services shall be issued such lower rate. For the fiscal years ending June 30, 2012, and June 30, 2013, the Commissioner of Social Services may provide fair rent increases to any facility that has undergone a material change in circumstances related to fair rent and has an approved certificate of need pursuant to section 17b-352, 17b-353, 17b-354 or 17b-355.

(2) The commissioner shall, upon determining that a loan to be issued to a residential care home by the Connecticut Housing Finance Authority is reasonable in relation to the useful life and property cost allowance pursuant to section 17-311-52 of the regulations of Connecticut state agencies, allow actual debt service, comprised of principal, interest and a repair and replacement reserve on the loan, in lieu of allowed property costs whether actual debt service is higher or lower than such allowed property costs.

(i) Notwithstanding the provisions of this section, the Commissioner of Social Services shall establish a fee schedule for payments to be made to chronic disease hospitals associated with chronic and convalescent nursing homes to be effective on and after July 1, 1995. The fee schedule may be adjusted annually beginning July 1, 1997, to reflect necessary increases in the cost of services.

Section 10. Section 17b-340a of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 17b-340a. Determination of resident day user fee in an intermediate care facility for [the mentally retarded] individuals with intellectual disabilities. Penalty. Delegation of authority to Commissioner of Social Services. (a) For purposes of this section and section 17b-340b:

(1) "Commissioner" means the Commissioner of Revenue Services;

(2) "Department" means the Department of Revenue Services;

(3) "Intermediate care facility for [the mentally retarded"] individuals with intellectual disabilities" or "intermediate care facility" means a residential facility for [the mentally retarded] persons with intellectual disability which is certified to meet the requirements of 42 CFR 442, Subpart C and, in the case of a private facility, licensed pursuant to section 17a-227;

(4) "Resident day" means a day of intermediate care facility residential care provided to an individual and includes the day a resident is admitted and any day for which the intermediate care facility is eligible for payment for reserving a resident's bed due to hospitalization or temporary

leave and for the date of death. For purposes of this subdivision, a day of care shall be the period of time between the census-taking hour in a facility on two successive calendar days. "Resident day" does not include the day a resident is discharged;

(5) "Intermediate care facility for [the mentally retarded] individuals with intellectual disabilities net revenue" means amounts billed by an intermediate care facility for all services provided, including room, board and ancillary services, minus (A) contractual allowances, (B) payer discounts, (C) charity care, and (D) bad debts; and

(6) "Contractual allowances" means the amount of discounts allowed by an intermediate care facility to certain payers from amounts billed for room, board and ancillary services.

(b) (1) For each calendar quarter commencing on or after July 1, 2011, there is hereby imposed a resident day user fee on each intermediate care facility for [the mentally retarded] individuals with intellectual disabilities in this state, which fee shall be the product of the facility's total resident days during the calendar quarter multiplied by the user fee, as determined by the Commissioner of Social Services pursuant to section 17b-340b.

(2) Each intermediate care facility for [the mentally retarded] individuals with intellectual disabilities shall, on or before the last day of January, April, July and October of each year, render to the commissioner a return, on forms prescribed or furnished by the commissioner, stating the intermediate care facility's total resident days during the calendar quarter ending on the last day of the preceding month and stating such other information as the commissioner deems necessary for the proper administration of the provisions of this section. The resident day user fee imposed under this section shall be due and payable on the due date of such return. Each intermediate care facility shall be required to file such return electronically with the department and to make such payment by electronic funds transfer in the manner provided by chapter 228g, irrespective of whether such facility would have otherwise been required to file such return electronically or to make such payment by electronic funds transfer under the provisions of chapter 228g.

(c) Whenever such resident day user fee is not paid when due, a penalty of ten per cent of the amount due or fifty dollars, whichever is greater, shall be imposed, and interest at the rate of one per cent per month or a fraction thereof shall accrue on such user fee from the due date of such user fee until the date of payment.

(d) The commissioner shall notify the Commissioner of Social Services of any amount delinquent under section 17b-340b and, upon receipt of such notice, the Commissioner of Social Services shall deduct and withhold such amount from amounts otherwise payable by the Department of Social Services to the delinquent facility.

(e) The provisions of section 12-548, sections 12-550 to 12-554, inclusive, and section 12-555a shall apply to the provisions of this section in the same manner and with the same force and effect as if the language of said sections had been incorporated in full into this section and had expressly referred to the user fee imposed under this section, except to the extent that any provision is inconsistent with a

provision in this section. For purposes of section 12-39g, the resident day user fee shall be treated as a tax.

(f) The commissioner may enter into an agreement with the Commissioner of Social Services delegating to the Commissioner of Social Services the authority to examine the records and returns of any intermediate care facility for [the mentally retarded] individuals with intellectual disabilities in this state subject to the resident day user fee imposed under this section and to determine whether such user fee has been underpaid or overpaid. If such authority is so delegated, examinations of such records and returns by the Commissioner of Social Services and determinations by the Commissioner of Social Services that such user fee has been underpaid or overpaid shall have the same effect as similar examinations or determinations made by the Commissioner of Revenue Services.

(g) (1) The commissioner shall not collect the resident day user fee pursuant to this section until the Commissioner of Social Services informs the commissioner that all the necessary federal approvals are in effect to secure federal financial participation matching funds associated with any authorized facility rate increases.

(2) The commissioner shall cease to collect the resident day user fee pursuant to this section if the Commissioner of Social Services informs the commissioner that the federal approvals described in subdivision (1) of this subsection are withheld or withdrawn.

Section 11. Section 17b-340b of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 17b-340b. Intermediate care facilities for [the mentally retarded.] individuals with intellectual disabilities. User fee. On or before July 1, 2011, and on or before July first annually or biennially thereafter, the Commissioner of Social Services shall determine the amount of the user fee and promptly notify the commissioner and the intermediate care facilities for [the mentally retarded] individuals with intellectual disabilities of such amount. The user fee shall be (1) the sum of each facility's anticipated net revenue, including, but not limited to, its estimated net revenue from any increases in Medicaid payments during the twelve-month period ending on June thirtieth of the succeeding calendar year, (2) which sum shall be multiplied by a percentage as determined by the Secretary of the Office of Policy and Management, in consultation with the Commissioner of Social Services, provided, before October 1, 2011, such percentage shall not exceed five and one-half per cent and, on and after October 1, 2011, such percentage shall not exceed the maximum amount allowed under federal law, and (3) which product shall be divided by the sum of each facility's anticipated resident days during the twelve-month period ending on June thirtieth of the succeeding calendar year. The Commissioner of Social Services, in anticipating facility net revenue and resident days, shall use the most recently available facility net revenue and resident day information. Notwithstanding the provisions of this section, the Commissioner of Social Services may adjust the user fee as necessary to prevent the state from exceeding the maximum amount allowed under federal law.

Section 12. Section 17b-352 of the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 17b-352. Certificate of need for nursing home facilities; transfer of ownership or control; introduction of additional function or service; termination or decrease of service. Notice to Office of the Long-Term Care Ombudsman. Notice and public hearing requirements. Regulations. (a) For the purposes of this section and section 17b-353, "facility" means a residential facility for [the mentally retarded] individuals with intellectual disabilities licensed pursuant to section 17a-277 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for [the mentally retarded,] individuals with intellectual disabilities, a nursing home, rest home or residential care home, as defined in section 19a-490.

(b) Any facility which intends to (1) transfer all or part of its ownership or control prior to being initially licensed; (2) introduce any additional function or service into its program of care or expand an existing function or service; or (3) terminate a service or decrease substantially its total bed capacity, shall submit a complete request for permission to implement such transfer, addition, expansion, increase, termination or decrease with such information as the department requires to the Department of Social Services, provided no permission or request for permission to close a facility is required when a facility in receivership is closed by order of the Superior Court pursuant to section 19a-545. The Office of the Long-Term Care Ombudsman pursuant to section 17b-400 shall be notified by the facility of any proposed actions pursuant to this subsection at the same time the request for permission is submitted to the department and when a facility in receivership is closed by order of the Superior Court pursuant to section 19a-545.

(c) An applicant, prior to submitting a certificate of need application, shall request, in writing, application forms and instructions from the department. The request shall include: (1) The name of the applicant or applicants; (2) a statement indicating whether the application is for (A) a new, additional, expanded or replacement facility, service or function, (B) a termination or reduction in a presently authorized service or bed capacity or (C) any new, additional or terminated beds and their type; (3) the estimated capital cost; (4) the town where the project is or will be located; and (5) a brief description of the proposed project. Such request shall be deemed a letter of intent. No certificate of need application shall be considered submitted to the department unless a current letter of intent, specific to the proposal and in accordance with the provisions of this subsection, has been on file with the department for not less than ten business days. For purposes of this subsection, "a current letter of intent" means a letter of intent on file with the department for not more than one hundred eighty days. A certificate of need application shall be deemed withdrawn by the department, if a department completeness letter is not responded to within one hundred eighty days. The Office of the Long-Term Care Ombudsman shall be notified by the facility at the same time as the letter of intent is submitted to the department.

(d) Any facility acting pursuant to subdivision (3) of subsection (b) of this section shall provide written notice, at the same time it submits its letter of intent, to all patients, guardians or conservators, if any, or legally liable relatives or other responsible parties, if known, and shall post such notice in a conspicuous location at the facility. The notice shall state the following: (A) The

projected date the facility will be submitting its certificate of need application, (B) that only the department has the authority to either grant, modify or deny the application, (C) that the department has up to ninety days to grant, modify or deny the certificate of need application, (D) a brief description of the reason or reasons for submitting a request for permission, (E) that no patient shall be involuntarily transferred or discharged within or from a facility pursuant to state and federal law because of the filing of the certificate of need application, (F) that all patients have a right to appeal any proposed transfer or discharge, and (G) the name, mailing address and telephone number of the Office of the Long-Term Care Ombudsman and local legal aid office.

(e) The department shall review a request made pursuant to subsection (b) of this section to the extent it deems necessary, including, but not limited to, in the case of a proposed transfer of ownership or control prior to initial licensure, the financial responsibility and business interests of the transferee and the ability of the facility to continue to provide needed services, or in the case of the addition or expansion of a function or service, ascertaining the availability of the function or service at other facilities within the area to be served, the need for the service or function within the area and any other factors the department deems relevant to a determination of whether the facility is justified in adding or expanding the function or service. The commissioner shall grant, modify or deny the request within ninety days of receipt thereof, except as otherwise provided in this section. Upon the request of the applicant, the review period may be extended for an additional fifteen days if the department has requested additional information subsequent to the commencement of the commissioner's review period. The director of the office of certificate of need and rate setting may extend the review period for a maximum of thirty days if the applicant has not filed in a timely manner information deemed necessary by the department. The applicant may request and shall receive a hearing in accordance with section 4-177 if aggrieved by a decision of the commissioner.

(f) The Commissioner of Social Services shall not approve any requests for beds in residential facilities for [the mentally retarded] persons with intellectual disability which are licensed pursuant to section 17a-227 and are certified to participate in the Title XIX Medicaid Program as intermediate care facilities for [the mentally retarded,] individuals with intellectual disabilities, except those beds necessary to implement the residential placement goals of the Department of Developmental Services which are within available appropriations.

(g) The Commissioner of Social Services shall adopt regulations, in accordance with chapter 54, to implement the provisions of this section. The commissioner shall implement the standards and procedures of the Office of Health Care Access division of the Department of Public Health concerning certificates of need established pursuant to section 19a-643, as appropriate for the purposes of this section, until the time final regulations are adopted in accordance with said chapter 54.

Section 13. Section 17b-356 of the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 17b-356. Health care facility proposing to expand services by adding nursing home beds. Procedures. Any health care facility or institution, as defined in subsection (a) of section 19a-490,

except a nursing home, rest home, residential care home or residential facility for [the mentally retarded] persons with intellectual disability licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for [the mentally retarded,] individuals with intellectual disabilities, proposing to expand its services by adding nursing home beds shall obtain the approval of the Commissioner of Social Services in accordance with the procedures established pursuant to sections 17b-352, 17b-353 and 17b-354 for a facility, as defined in section 17b-352, prior to obtaining the approval of the Office of Health Care Access division of the Department of Public Health pursuant to section 19a-639.

Section 14. Section 17b-363b of the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 17b-363b. Reimbursement for pharmacy services for long-term care facilities. (a) The Commissioner of Social Services may, within available appropriations, provide reimbursement to pharmacies or pharmacists for services provided to residents in long-term care facilities, including (1) residential care homes, nursing homes or rest homes, as defined in section 19a-490, (2) residential facilities for [mentally retarded persons,] persons with intellectual disability, as defined in section 17a-231, or (3) facilities served by assisted living services agencies, as defined in section 19a-490, in addition to those reimbursements provided in chapter 319v, provided such services improve the quality of care to residents of such facilities and produce cost savings to the state, as determined by the commissioner. Such services may include, but not be limited to, emergency and delivery services provided such services are offered on all medications, including intravenous therapy, twenty-four hours per day and seven days per week.

(b) The Commissioner of Social Services may reimburse for prescription drug costs in unit dose packaging, including blister packs and other special packaging, for clients residing in nursing facilities, chronic disease hospitals and intermediate care facilities for [the mentally retarded.] individuals with intellectual disabilities.

Section 15. Section 19a-490 of the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 19a-490. (Formerly Sec. 19-576). Licensing of institutions. Definitions. As used in this chapter and sections 17b-261e, 38a-498b and 38a-525b:

(a) "Institution" means a hospital, residential care home, health care facility for the handicapped, nursing home, rest home, home health care agency, homemaker-home health aide agency, mental health facility, assisted living services agency, substance abuse treatment facility, outpatient surgical facility, an infirmary operated by an educational institution for the care of students enrolled in, and faculty and employees of, such institution; a facility engaged in providing services for the prevention, diagnosis, treatment or care of human health conditions, including facilities operated and maintained by any state agency, except facilities for the care or treatment of mentally ill persons or persons with substance abuse problems; and a residential facility for [the mentally retarded] persons with intellectual disability licensed pursuant to section 17a-227 and certified to participate in the

Title XIX Medicaid program as an intermediate care facility for [the mentally retarded;] individuals with intellectual disabilities;

(b) "Hospital" means an establishment for the lodging, care and treatment of persons suffering from disease or other abnormal physical or mental conditions and includes inpatient psychiatric services in general hospitals;

(c) "Residential care home", "nursing home" or "rest home" means an establishment which furnishes, in single or multiple facilities, food and shelter to two or more persons unrelated to the proprietor and, in addition, provides services which meet a need beyond the basic provisions of food, shelter and laundry;

(d) "Home health care agency" means a public or private organization, or a subdivision thereof, engaged in providing professional nursing services and the following services, available twenty-four hours per day, in the patient's home or a substantially equivalent environment: Homemaker-home health aide services as defined in this section, physical therapy, speech therapy, occupational therapy or medical social services. The agency shall provide professional nursing services and at least one additional service directly and all others directly or through contract. An agency shall be available to enroll new patients seven days a week, twenty-four hours per day;

(e) "Homemaker-home health aide agency" means a public or private organization, except a home health care agency, which provides in the patient's home or a substantially equivalent environment supportive services which may include, but are not limited to, assistance with personal hygiene, dressing, feeding and incidental household tasks essential to achieving adequate household and family management. Such supportive services shall be provided under the supervision of a registered nurse and, if such nurse determines appropriate, shall be provided by a social worker, physical therapist, speech therapist or occupational therapist. Such supervision may be provided directly or through contract;

(f) "Homemaker-home health aide services" as defined in this section shall not include services provided to assist individuals with activities of daily living when such individuals have a disease or condition that is chronic and stable as determined by a physician licensed in the state of Connecticut;

(g) "Mental health facility" means any facility for the care or treatment of mentally ill or emotionally disturbed persons, or any mental health outpatient treatment facility that provides treatment to persons sixteen years of age or older who are receiving services from the Department of Mental Health and Addiction Services, but does not include family care homes for the mentally ill;

(h) "Alcohol or drug treatment facility" means any facility for the care or treatment of persons suffering from alcoholism or other drug addiction;

(i) "Person" means any individual, firm, partnership, corporation, limited liability company or association;

(j) "Commissioner" means the Commissioner of Public Health;

(k) "Home health agency" means an agency licensed as a home health care agency or a homemaker-home health aide agency; and

(l) "Assisted living services agency" means an agency that provides, among other things, nursing services and assistance with activities of daily living to a population that is chronic and stable.

Section 16. Section 19a-491c of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 19a-491c. Criminal history and patient abuse background search program. Regulations. (a) As used in this section:

(1) "Criminal history and patient abuse background search" or "background search" means (A) a review of the registry of nurse's aides maintained by the Department of Public Health pursuant to section 20-102bb, (B) checks of state and national criminal history records conducted in accordance with section 29-17a, and (C) a review of any other registry specified by the Department of Public Health which the department deems necessary for the administration of a background search program.

(2) "Direct access" means physical access to a patient or resident of a long-term care facility that affords an individual with the opportunity to commit abuse or neglect against or misappropriate the property of a patient or resident.

(3) "Disqualifying offense" means a conviction of any crime described in 42 USC 1320a-7(a)(1), (2), (3) or (4) or a substantiated finding of neglect, abuse or misappropriation of property by a state or federal agency pursuant to an investigation conducted in accordance with 42 USC 1395i-3(g)(1)(C) or 42 USC 1396r(g)(1)(C).

(4) "Long-term care facility" means any facility, agency or provider that is a nursing home, as defined in section 19a-521, a home health agency, as defined in section 19a-490, an assisted living services agency, as defined in section 19a-490, an intermediate care facility for [the mentally retarded,] <u>individuals with intellectual disabilities,</u> as defined in 42 USC 1396d(d), a chronic disease hospital, as defined in section 19a-550, or an agency providing hospice care which is licensed to provide such care by the Department of Public Health or certified to provide such care pursuant to 42 USC 1395x.

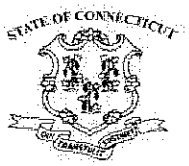
(b) (1) On or before July 1, 2012, the Department of Public Health shall create and implement a criminal history and patient abuse background search program, within available appropriations, in order to facilitate the performance, processing and analysis of the criminal history and patient abuse background search of individuals who have direct access.

(2) The Department of Public Health shall develop a plan to implement the criminal history and patient abuse background search program, in accordance with this section. In developing such plan, the department shall (A) consult with the Commissioners of Emergency Services and Public Protection, Developmental Services, Mental Health and Addiction Services, Social Services and Consumer Protection, or their designees, the State Long-Term Care Ombudsman, or a designee, the chairperson for the Board of Pardons and Paroles, or a designee, a representative of each category of long-term care facility and representatives from any other agency or organization the Commissioner of Public Health deems appropriate, (B) evaluate factors including, but not limited to, the administrative and fiscal impact of components of the program on state agencies and long-term care facilities, background check procedures currently used by long-term care facilities, federal requirements pursuant to Section 6201 of the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, and the effect of full and provisional pardons on employment, and (C) outline (i) an integrated process with the Department of Public Safety to cross-check and periodically update criminal information collected in criminal databases, (ii) a process by which individuals with disqualifying offenses can apply for a waiver, and (iii) the structure of an Internet-based portal to streamline the criminal history and patient abuse background search program. The Department of Public Health shall submit such plan, including a recommendation as to whether homemaker-companion agencies should be included in the scope of the background search program, to the joint standing committees of the General Assembly having cognizance of matters relating to aging, appropriations and the budgets of state agencies, and public health, in accordance with the provisions of section 11-4a, not later than February 1, 2012.

(c) (1) Except as provided in subdivision (2) of this subsection, each long-term care facility, prior to extending an offer of employment to or entering into a contract for the provision of long-term care services with any individual who will have direct access, or prior to allowing any individual to have direct access while volunteering at such long-term care facility, shall require that such individual submit to a background search. The Department of Public Health shall prescribe the manner by which (A) long-term care facilities perform the review of (i) the registry of nurse's aides maintained by the department pursuant to section 20-102bb, and (ii) any other registry specified by the department, including requiring long-term care facilities to report the results of such review to the department, and (B) individuals submit to state and national criminal history records checks, including requiring the Department of Emergency Services and Public Protection to report the results of such checks to the Department of Public Health.

(2) No long-term care facility shall be required to comply with the provisions of this subsection if the individual provides evidence to the long-term care facility that such individual submitted to a background search conducted pursuant to subdivision (1) of this subsection not more than three years immediately preceding the date such individual applies for employment, seeks to enter into a contract or begins volunteering with the long-term care facility and that the prior background search confirmed that the individual did not have a disqualifying offense.

(d) (1) The Department of Public Health shall review all reports provided to the department pursuant to subsection (c) of this section. If any such report contains evidence indicating that an individual has a disqualifying offense, the department shall provide notice to the individual and the long-term



care facility indicating the disqualifying offense and providing the individual with the opportunity to file a request for a waiver pursuant to subdivisions (2) and (3) of this subsection.

(2) An individual may file a written request for a waiver with the department not later than thirty days after the date the department mails notice to the individual pursuant to subdivision (1) of this subsection. The department shall mail a written determination indicating whether the department shall grant a waiver pursuant to subdivision (3) of this subsection not later than fifteen business days after the department receives the written request from the individual, except that said time period shall not apply to any request for a waiver in which an individual challenges the accuracy of the information obtained from the background search.

(3) The department may grant a waiver from the provisions of subsection (e) of this section to an individual who identifies mitigating circumstances surrounding the disqualifying offense, including (A) inaccuracy in the information obtained from the background search, (B) lack of a relationship between the disqualifying offense and the position for which the individual has applied, (C) evidence that the individual has pursued or achieved rehabilitation with regard to the disqualifying offense, or (D) that substantial time has elapsed since committing the disqualifying offense. The department and its employees shall be immune from liability, civil or criminal, that might otherwise be incurred or imposed, for good faith conduct in granting waivers pursuant to this subdivision.

(4) After completing a review pursuant to subdivision (1) of this subsection, the department shall notify in writing the long-term care facility to which the individual has applied for employment or with which the individual seeks to enter into a contract or volunteer (A) of any disqualifying offense and any information the individual provided to the department regarding mitigating circumstances surrounding such offense, or of the lack of a disqualifying offense, and (B) whether the department granted a waiver pursuant to subdivision (3) of this subsection.

(e) Notwithstanding the provisions of section 46a-80, no long-term care facility shall employ an individual required to submit to a background search, contract with any such individual to provide long-term care services or allow such individual to volunteer if the long-term care facility receives notice from the department that the individual has a disqualifying offense in the individual's background search and the department has not granted a waiver pursuant to subdivision (3) of subsection (d) of this section. A long-term care facility may, but is not obligated to, employ, enter into a contract with or allow to volunteer an individual who was granted a waiver pursuant to said subdivision (3).

(f) (1) Except as provided in subdivision (2) of this subsection, a long-term care facility shall not employ, enter into a contract with or allow to volunteer any individual required to submit to a background search until the long-term care facility receives notice from the Department of Public Health pursuant to subdivision (4) of subsection (d) of this section.

(2) A long-term care facility may employ, enter into a contract with or allow to volunteer an individual required to submit to a background search on a conditional basis before the long-term care facility receives notice from the department that such individual does not have a disqualifying

offense, provided: (A) The employment or contractual or volunteer period on a conditional basis shall last not more than sixty days, (B) the long-term care facility has begun the review required under subsection (c) of this section and the individual has submitted to checks pursuant to subsection (c) of this section, (C) the individual is subject to direct, on-site supervision during the course of such conditional employment or contractual or volunteer period, and (D) the individual, in a signed statement (i) affirms that the individual has not committed a disqualifying offense, and (ii) acknowledges that a disqualifying offense reported in the background search required by subsection (c) of this section shall constitute good cause for termination and a long-term care facility may terminate the individual if a disqualifying offense is reported in said background search.

(g) Notwithstanding the provisions of subsection (b) of this section, the department may phase in implementation of the criminal history and patient abuse background search program by category of long-term care facility. No long-term care facility shall be required to comply with the provisions of subsections (c), (e) and (f) of this section until the date notice is published by the Commissioner of Public Health in the Connecticut Law Journal indicating that the commissioner is implementing the criminal history and patient abuse background search program for the category of such long-term care facility.

(h) The department shall adopt regulations, in accordance with the provisions of chapter 54, to implement the provisions of this section. The department may implement policies and procedures consistent with the provisions of this section while in the process of adopting such policies and procedures as regulation, provided notice of intention to adopt regulations is printed in the Connecticut Law Journal not later than twenty days after the date of implementation. Such policies and procedures shall be valid until the time final regulations are effective.

Section 17. Section 19a-638 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 19a-638. (Formerly Sec. 19a-154). Certificate of need. When required and not required. Request for office determination. Policies, procedures and regulations. (a) A certificate of need issued by the office shall be required for:

(1) The establishment of a new health care facility;

(2) A transfer of ownership of a health care facility;

(3) The establishment of a free-standing emergency department;

(4) The termination of inpatient or outpatient services offered by a hospital, including, but not limited to, the termination by a short-term acute care general hospital or children's hospital of inpatient and outpatient mental health and substance abuse services;

(5) The establishment of an outpatient surgical facility, as defined in section 19a-493b, or as established by a short-term acute care general hospital;

(6) The termination of surgical services by an outpatient surgical facility, as defined in section 19a-493b, or a facility that provides outpatient surgical services as part of the outpatient surgery department of a short-term acute care general hospital, provided termination of outpatient surgical services due to (A) insufficient patient volume, or (B) the termination of any subspecialty surgical service, shall not require certificate of need approval;

(7) The termination of an emergency department by a short-term acute care general hospital;

(8) The establishment of cardiac services, including inpatient and outpatient cardiac catheterization, interventional cardiology and cardiovascular surgery;

(9) The acquisition of computed tomography scanners, magnetic resonance imaging scanners, positron emission tomography scanners or positron emission tomography-computed tomography scanners, by any person, physician, provider, short-term acute care general hospital or children's hospital, except as provided for in subdivision (22) of subsection (b) of this section;

(10) The acquisition of nonhospital based linear accelerators;

(11) An increase in the licensed bed capacity of a health care facility;

(12) The acquisition of equipment utilizing technology that has not previously been utilized in the state;

(13) An increase of two or more operating rooms within any three-year period, commencing on and after October 1, 2010, by an outpatient surgical facility, as defined in section 19a-493b, or by a short-term acute care general hospital; and

(14) The termination of inpatient or outpatient services offered by a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended.

(b) A certificate of need shall not be required for:

(1) Health care facilities owned and operated by the federal government;

(2) The establishment of offices by a licensed private practitioner, whether for individual or group practice, except when a certificate of need is required in accordance with the requirements of section 19a-493b or subdivision (9) or (10) of subsection (a) of this section;

(3) A health care facility operated by a religious group that exclusively relies upon spiritual means through prayer for healing;

(4) Residential care homes, nursing homes and rest homes, as defined in subsection (c) of section 19a-490;

(5) An assisted living services agency, as defined in section 19a-490;

(6) Home health agencies, as defined in section 19a-490;

(7) Hospice services, as described in section 19a-122b;

(8) Outpatient rehabilitation facilities;

(9) Outpatient chronic dialysis services;

(10) Transplant services;

(11) Free clinics, as defined in section 19a-630;

(12) School-based health centers, community health centers, as defined in section 19a-490a, not-for-profit outpatient clinics licensed in accordance with the provisions of chapter 368v and federally qualified health centers;

(13) A program licensed or funded by the Department of Children and Families, provided such program is not a psychiatric residential treatment facility;

(14) Any nonprofit facility, institution or provider that has a contract with, or is certified or licensed to provide a service for, a state agency or department for a service that would otherwise require a certificate of need. The provisions of this subdivision shall not apply to a short-term acute care general hospital or children's hospital, or a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended;

(15) A health care facility operated by a nonprofit educational institution exclusively for students, faculty and staff of such institution and their dependents;

(16) An outpatient clinic or program operated exclusively by or contracted to be operated exclusively by a municipality, municipal agency, municipal board of education or a health district, as described in section 19a-241;

(17) A residential facility for persons with intellectual disability licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for [the mentally retarded;] individuals with intellectual disabilities;

(18) Replacement of existing imaging equipment if such equipment was acquired through certificate of need approval or a certificate of need determination, provided a health care facility, provider, physician or person notifies the office of the date on which the equipment is replaced and the disposition of the replaced equipment;

(19) Acquisition of cone-beam dental imaging equipment that is to be used exclusively by a dentist licensed pursuant to chapter 379;

(20) The partial or total elimination of services provided by an outpatient surgical facility, as defined in section 19a-493b, except as provided in subdivision (6) of subsection (a) of this section and section 19a-639e;

(21) The termination of services for which the Department of Public Health has requested the facility to relinquish its license; or

(22) Acquisition of any equipment by any person that is to be used exclusively for scientific research that is not conducted on humans.

(c) (1) Any person, health care facility or institution that is unsure whether a certificate of need is required under this section, or (2) any health care facility that proposes to relocate pursuant to section 19a-639c shall send a letter to the office that describes the project and requests that the office make a determination as to whether a certificate of need is required. In the case of a relocation of a health care facility, the letter shall include information described in section 19a-639c. A person, health care facility or institution making such request shall provide the office with any information the office requests as part of its determination process.

(d) The Commissioner of Public Health may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the commissioner holds a public hearing prior to implementing the policies and procedures and prints notice of intent to adopt regulations in the Connecticut Law Journal not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted. Final regulations shall be adopted by December 31, 2011.

Agency Legislative Proposal - 2013 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
10-1-12 DDS DDS Councils

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Department of Developmental Services (DDS)

Liaison: Rod O'Connor
Phone: 860-418-6130
E-mail: rod.oconnor@ct.gov

Lead agency division requesting this proposal: Commissioner's Office, Birth to Three

Agency Analyst/Drafter of Proposal: Rod O'Connor, Linda Goodman

Title of Proposal
An Act Concerning Revisions to Various Councils by the Department of Developmental Services

Statutory Reference: Sections 17a-215c, 17a-217a, 17a-248, and 17a-248b CGS

Proposal Summary
This legislative proposal revises an appointment to the Camp Harkness Advisory Committee, sets term limits and revises appointments for the Birth to Three Interagency Coordinating Council and creates a new Autism Spectrum Disorder Advisory Council as a successor to the independent council created by Public Act 06-188 and the Autism Feasibility Study Workgroup created by Public Act 11-6.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
Yes, the federal IDEA, Part C has revised the appointments it requires for the states' federally mandated Interagency Coordinating Council. The state statute for the Autism Pilot Program (17a-215b) where the Independent council for the Autism Pilot Program was established has been repealed.

(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
No

(3) Have certain constituencies called for this action?
No

(4) What would happen if this was not enacted in law this session? The Birth to Three Interagency

Coordinating Council would continue but out of compliance with federal IDEA, Part C. The Camp Harkness Advisory Committee would continue to be short one Family Support Council member. There would continue to be two entities with oversight responsibilities for autism services. One of these entities has no statutory charge or mechanism for appointment.

- **Origin of Proposal** **_X_ New Proposal** **___ Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name:
Agency Contact (name, title, phone):
Date Contacted:

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) None

State: None

Federal: None

Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Sections 1 and 2 would create an Autism Spectrum Disorder Advisory Council in succession to the Independent Council set up for the Autism Pilot Program. The Independent Council currently has no statutory charge and has no statutory mechanism for appointments. The new Autism Council would also incorporate the mission and responsibilities of the Autism Feasibility Study Workgroup and the workgroup's recommendation for an on-going ASD Implementation Advisory Committee. Section 3 would allow the Family Support Council to be represented on the Camp Harkness Advisory Committee. Sections 4 and 5 would align Connecticut's Interagency Coordinating Council (ICC) with the federal IDEA, Part C requirements for membership to the Council and would impose term limits for certain appointments to the ICC

An Act Concerning Revisions to Various Councils by the Department of Developmental Services.

Be it enacted by the Senate and House of Representatives in the General Assembly Convened:

Section 1. Section 17a-215c of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof:

Sec. **17a-215c.** Division of Autism Spectrum Disorder Services. Services and programs for state residents diagnosed with autism spectrum disorder. (a) There is established a Division of Autism Spectrum Disorder Services within the Department of Developmental Services.

(b) The Department of Developmental Services shall adopt regulations, in accordance with chapter 54, to define the term "autism spectrum disorder", establish eligibility standards and criteria for the receipt of services by any resident of the state diagnosed with autism spectrum disorder, regardless of age, and data collection, maintenance and reporting processes. The commissioner may implement policies and procedures necessary to administer the provisions of this section prior to adoption of such regulations, provided the commissioner shall publish notice of intent to adopt such regulations not later than twenty days after implementation of such policies and procedures. Any such policies and procedures shall be valid until such regulations are adopted.

(c) The Division of Autism Spectrum Disorder Services may, within available appropriations, research, design and implement the delivery of appropriate and necessary services and programs for all residents of the state with autism spectrum disorder. Such services and programs may include the creation of: (1) Autism-specific early intervention services for any child under the age of three diagnosed with autism spectrum disorder; (2) education, recreation, habilitation, vocational and transition services for individuals age three to twenty-one, inclusive, diagnosed with autism spectrum disorder; (3) services for adults over the age of twenty-one diagnosed with autism spectrum disorder; and (4) related autism spectrum disorder services deemed necessary by the Commissioner of Developmental Services.

(d) The Department of Developmental Services shall serve as the lead state agency for the purpose of the federal Combating Autism Act, P.L. 109-416 and for applying for and receiving funds and performing any related responsibilities concerning autism spectrum disorder which are authorized pursuant to any state or federal law.

(e) On or before February 1, 2009, and annually thereafter, the Department of Developmental Services may make recommendations to the Governor and the joint standing committee of the General Assembly having cognizance of matters relating to public health concerning legislation and funding required to provide necessary services to persons diagnosed with autism spectrum disorder.

(f) The Division of Autism Spectrum Disorder Services shall research and locate possible funding streams for the continued development and implementation of services for persons diagnosed with autism spectrum disorder but not with intellectual disability. The division shall take all necessary action, in coordination with the Department of Social Services, to secure Medicaid reimbursement for home and community-based individualized support services for adults diagnosed with autism spectrum disorder but not with intellectual disability. Such action may include applying for a Medicaid waiver pursuant to Section 1915(c) of the Social Security Act, in order to secure the funding for such services.

(g) The Division of Autism Spectrum Disorder Services shall, within available appropriations: (1) Design and implement a training initiative that shall include training to develop a workforce; and (2) develop a curriculum specific to autism spectrum disorder in coordination with the Board of Regents for Higher Education.

(h) The case records of the Division of Autism Spectrum Disorder Services maintained by the division for any purpose authorized pursuant to subsections (b) to (g), inclusive, of this section shall be subject to the same confidentiality requirements, under state and federal law, that govern all client records maintained by the Department of Developmental Services.

(i) The Commissioner of Social Services, in consultation with the Commissioner of Developmental Services, may seek approval of an amendment to the state Medicaid plan or a waiver from federal law, whichever is sufficient and most expeditious, to establish and implement a Medicaid-financed home and community-based program to provide community-based services and, if necessary, housing assistance, to adults diagnosed with autism spectrum disorder but not with intellectual disability.

(j) On or before January 1, 2008, and annually thereafter, the Commissioner of Social Services, in consultation with the Commissioner of Developmental Services, and in accordance with the provisions of section 11-4a, shall submit a report to the joint standing committee of the General Assembly having cognizance of matters relating to public health, on the status of any amendment to the state Medicaid plan or waiver from federal law as described in subsection (i) of this section and on the establishment and implementation of the program authorized pursuant to subsection (i) of this section.

(k) [The independent council established in connection with the autism spectrum disorder pilot program previously operated by the Department of Developmental Services shall continue to] The Autism Spectrum Disorder Advisory Council shall advise the Commissioner of Developmental Services on all matters relating to autism.

Section 2. NEW Section:

(NEW) Autism Spectrum Disorder Advisory Council. (a) There is established an Autism Spectrum Disorder Advisory Council which shall be a successor to the independent council created by Public Act 06-188 and the Autism Feasibility Study Workgroup created by Public Act 11-6. The council shall consist of twenty-two voting members including the Commissioners of Children and Families, Developmental Services, Education, Mental Health and Addiction Services, Public Health, Rehabilitation Services and Social Services and the Secretary of the Office of Policy and Management, or their designees, and individuals with Autism Spectrum Disorder, family members of, persons who advocate for, licensed professionals who work with, organizations which provide services for, and representatives of higher education institutions with expertise in individuals with autism spectrum disorder. Members, other than the Commissioners and the Secretary, or their designees, shall be appointed as follows: Six shall be appointed by the Governor, one of whom shall be a person with autism spectrum disorder, one of whom shall be a parent or guardian of a child with autism spectrum disorder, one of whom shall be an advocate for persons with autism spectrum disorder, one of whom shall be a licensed professional in the field of autism spectrum disorder, one of whom shall provide services for persons with autism spectrum disorder and one of whom shall be a representative of a Connecticut higher education institution with an expertise in the field of autism spectrum disorder to serve for terms of two years each; eight shall be appointed by members of the General Assembly for two-year terms, two of whom shall be a parent or a guardian of an adult with autism spectrum disorder, one appointed by the president pro tempore of the Senate, and one appointed by the majority leader of the House; one of whom shall be a parent or a guardian of a child with autism spectrum disorder, appointed by the minority leader of the Senate; one of whom shall be a representative of a Connecticut higher education institution with an expertise in the field of autism spectrum disorder, appointed by the president pro tempore of the Senate; one of whom shall be a person with autism spectrum disorder, appointed by the speaker of the House; one of whom shall be an advocate for persons with autism spectrum disorder, appointed by the speaker of the House; one of whom shall be a licensed professional in the field of autism spectrum disorder, appointed by the majority leader of the Senate; and one of whom shall provide services for persons with autism spectrum disorder. No appointed member of the council may serve more than three consecutive terms, except that a member may continue to serve until a successor is appointed. The members of the council shall serve without compensation except for necessary expenses incurred in performing their duties. The council may make rules for the conduct of its affairs. The council shall meet at least bimonthly and at other times upon the call of the chair or the written request of any two members.

(b) The council shall consider and advise on such matters as its members may request. The council shall consult with the Commissioner of Developmental Services on the administration of the Division of Autism Spectrum Disorder Services. The council may recommend to the Governor and to the General Assembly such legislation as will in its judgment improve the supports and services for persons with autism spectrum disorder.

Section 3. Section 17a-217a of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof:

Sec. **17a-217a**. Camp Harkness Advisory Committee. (a) There shall be a Camp Harkness Advisory Committee to advise the Commissioner of Developmental Services with respect to issues concerning the health and safety of persons who attend and utilize the facilities at Camp Harkness. The advisory committee shall be composed of twelve members as follows: (1) The director of Camp Harkness, who shall serve ex officio, one member representing the Southeastern Connecticut Association for Developmental Disabilities, one member representing the Southbury Training School, one member representing the Arc of New London County, one consumer representing persons who use the camp on a residential basis and one member representing parents or guardians of persons who use the camp, all of whom shall be appointed by the Governor; (2) one member representing parents or guardians of persons who use the camp, who shall be appointed by the president pro tempore of the Senate; (3) one [consumer from] member of the Family Support Council established pursuant to section 17a-219c representing persons who use the camp on a day basis, who shall be appointed by the speaker of the House of Representatives; (4) one member representing the board of selectmen of the town of Waterford, who shall be appointed by the majority leader of the House of Representatives; (5) one member representing a private nonprofit corporation that is: (A) Tax exempt under Section 501(c)(3) of the Internal Revenue Code of 1986, or any subsequent internal revenue code of the United States, as amended from time to time, and (B) established to promote and support Camp Harkness and its camping programs, who shall be appointed by the majority leader of the Senate; (6) one member representing the Connecticut Institute for the Blind and the Oak Hill School, who shall be appointed by the minority leader of the House of Representatives; and (7) one member representing the United Cerebral Palsy Association, who shall be appointed by the minority leader of the Senate.

(b) The advisory committee shall promote communication regarding camp services and develop recommendations for the commissioner regarding the use of Camp Harkness.

Section 4. Section 17a-248 of the 2012 supplement to the general statutes as amended by Public Act 12-1 of the June 12 Special Session is repealed and the following is substituted in lieu thereof:

Sec. **17a-248**. Birth-to-three program. Definitions. As used in this section and sections 17a-248b to 17a-248g, inclusive, 38a-490a and 38a-516a, unless the context otherwise requires:

(1) "Commissioner" means the Commissioner of Developmental Services.

(2) "Council" means the State Interagency Birth-to-Three Coordinating Council established pursuant to section 17a-248b.

(3) "Early intervention services" means early intervention services, as defined in [34 CFR Part 303.12,] 34 CFR Part 303.13, as from time to time amended.

(4) "Eligible children" means children from birth to thirty-six months of age, who are not eligible for special education and related services pursuant to sections 10-76a to 10-76h, inclusive, and who need early intervention services because such children are:

(A) Experiencing a significant developmental delay as measured by standardized diagnostic instruments and procedures, including informed clinical opinion, in one or more of the following areas: (i) Cognitive development; (ii) physical development, including vision or hearing; (iii) communication development; (iv) social or emotional development; or (v) adaptive skills; or

(B) Diagnosed as having a physical or mental condition that has a high probability of resulting in developmental delay.

(5) "Evaluation" means a multidisciplinary professional, objective assessment conducted by appropriately qualified personnel in order to determine a child's eligibility for early intervention services.

(6) "Individualized family service plan" means a written plan for providing early intervention services to an eligible child and the child's family.

(7) "Lead agency" means the Department of Developmental Services, the public agency responsible for the administration of the birth-to-three system in collaboration with the participating agencies.

(8) "Parent" means (A) a biological, adoptive or foster parent of a child; (B) a guardian, except for the Commissioner of Children and Families; (C) an individual acting in the place of a biological or adoptive parent, including, but not limited to, a grandparent, stepparent, or other relative with whom the child lives; (D) an individual who is legally responsible for the child's welfare; or (E) an individual appointed to be a surrogate parent.

(9) "Participating agencies" includes, but is not limited to, the Departments of Education, Social Services, Public Health, Children and Families and Developmental Services, the Insurance Department, the Bureau of Education and Services for the Blind and the Commission on the Deaf and Hearing Impaired within the Department of Rehabilitation Services and the Office of Protection and Advocacy for Persons with Disabilities.

(10) "Qualified personnel" means persons who meet the standards specified in [34 CFR Part 303.12(e),] 34 CFR Part 303.31, as from time to time amended, and who are licensed physicians or psychologists or persons holding a state-approved or recognized license, certificate or registration in one or more of the following fields: (A) Special education, including teaching of the blind and the deaf; (B) speech and language pathology and audiology; (C) occupational therapy; (D) physical therapy; (E) social work; (F) nursing; (G) dietary or nutritional counseling; and (H) other fields designated by the commissioner that meet requirements that apply to the area in which the person is providing early intervention services, provided there is no conflict with existing professional licensing, certification and registration requirements.

(11) "Service coordinator" means a person carrying out service coordination, as defined in [34 CFR Part 303.22,] 34 CFR Part 303.34, as from time to time amended.

(12) "Primary care provider" means physicians and advanced practice registered nurses, licensed by the Department of Public Health, who are responsible for performing or directly supervising the primary care services for children enrolled in the birth-to-three program.

Section 5. Section 17a-248b of the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 17a-248b. State Interagency Birth-to-Three Coordinating Council. (a) The lead agency shall establish a State Interagency Birth-to-Three Coordinating Council and shall provide staff assistance and other resources to the council. The council shall consist of the following members, appointed by the Governor: (1) Parents, including minority parents, of children with disabilities twelve years of age or younger, with knowledge of, or experience with, programs for children with disabilities from birth to thirty-six months of age, the total number of whom shall equal not less than twenty per cent of the total membership of the council, and at least one of whom shall be a parent of a child six years of age or younger, with a disability; (2) two members of the General Assembly at the time of their appointment, one of whom shall be designated by the speaker of the House of Representatives and one of whom shall be designated by the president pro tempore of the Senate; (3) one person involved in the training of personnel who provide early intervention services; (4) one person who is a member or a representative of the American Academy of Pediatrics; (5) one person from each of the participating agencies, including the State Coordinator of Education for Homeless Children and Youth and the State Coordinator for Early Childhood Special Education, who shall be designated by the commissioner or executive director of the participating agency and who have authority to engage in policy planning and implementation on behalf of the participating agency; (6) public or private providers of early intervention services, the total number of whom shall equal not less than twenty per cent of the total membership of the council; and (7) a representative of a Head Start program or agency. The Governor shall designate the chairperson of the council who shall not be the designee of the lead agency.

(b) The Governor shall appoint all members of the council for terms of three years. Except for persons appointed from participating agencies, no member of the council may serve more than two consecutive terms, except that a member may continue to serve until a successor is appointed. Any appointed member serving on October 1, 2013, and having served two or more consecutive terms shall not be eligible for reappointment within a three year period upon the completion of such member's current term.

(c) The council shall meet at least quarterly and shall provide public notice of its meetings, which shall be open and accessible to the general public. Special meetings may be called by the chairperson and shall be called at the request of the commissioner.

(d) Council members who are parents of children with disabilities shall be reimbursed for reasonable and necessary expenses incurred in the performance of their duties under this section.

(e) The council shall: (1) Assist the lead agency in the effective performance of the lead agency's responsibilities under section 17a-248, this section and sections 17a-248c to 17a-248g, inclusive, 38a-490a and 38a-516a, including identifying the sources of fiscal support for early intervention services and programs, assignment of financial responsibility to the appropriate agency, promotion of interagency agreements and preparing applications and amendments required pursuant to federal law; (2) advise and assist the commissioner and other participating agencies in the development of standards and procedures pursuant to said sections; (3) advise and assist the commissioner and the Commissioner of Education regarding the transition of children with disabilities to services provided under sections 10-76a to 10-76h, inclusive; (4) advise and assist the commissioner in identifying barriers that impede timely and effective service delivery, including advice and assistance with regard to interagency disputes; and (5) prepare and submit an annual report in accordance with section 11-4a to the Governor and the General Assembly on the status of the birth-to-three system. At least thirty days prior to the commissioner's final approval of rules and regulations pursuant to section 17a-248, this section, sections 17a-248c to 17a-248g, inclusive, 38a-490a and 38a-516a, other than emergency rules and regulations, the commissioner shall submit proposed rules and regulations to the council for its review. The council shall review all proposed rules and regulations and report its recommendations thereon to the commissioner within thirty days. The commissioner shall not act in a manner inconsistent with the recommendations of the council without first providing the reasons for such action. The council, upon a majority vote of its members, may require that an alternative approach to the proposed rules and regulations be published with a notice of the proposed rules and regulations pursuant to chapter 54. When an alternative approach is published pursuant to this section, the commissioner shall state the reasons for not selecting such alternative approach.

Agency Legislative Proposal - 2013 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
10-1-12 DDS Reporting Req

(If submitting an electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency:
Department of Developmental Services (DDS)

Liaison: Rod O'Connor
Phone: 860-418-6130
E-mail: rod.oconnor@ct.gov

Lead agency division requesting this proposal: Commissioner's Office

Agency Analyst/Drafter of Proposal: Christine Pollio Cooney, Rod O'Connor

Title of Proposal: An Act Eliminating a Reporting Requirement

Statutory Reference: Sections 4-61hh, 4-61ii, and 4-61mm CGS

Proposal Summary
This legislative proposal would eliminate the reporting requirement to the General Assembly by all state agencies of (1) The total number, location and duties of all volunteers; and (2) the total number of annual hours of service provided by all volunteers.

Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(1) *Have there been changes in federal/state/local laws and regulations that make this legislation necessary?*
Yes, DDS's annual report to the Committee of Cognizance was eliminated two years ago which would have been where DDS would have reported this information.

(2) *Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?*
No

(3) *Have certain constituencies called for this action?*
No

(4) *What would happen if this was not enacted in law this session? Several agencies would be out of compliance with the statute as written. DDS would continue to collect this volunteer data for insurance purposes but would still have nowhere to submit the information to the General Assembly.*

- **Origin of Proposal** _X_ **New Proposal** ___ **Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?

(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?

(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?

(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: DCF, DPH, DSS, DMHAS
Agency Contact (name, title, phone):
Date Contacted: 8-16-12

Approve of Proposal _X_ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

Most of the agencies contacted would not mind if the reporting requirement were to be repealed. Some weren't sure if they ever reported this information or collected it. DDS and other agencies do report volunteer information to the DAS/State Insurance & Risk Management Board but most agencies do not have an "annual report to the General Assembly" as section 4-61mm CGS assumes. The collection of the volunteer data would continue for purposes of the Insurance and Risk Management Board.

Will there need to be further negotiation? _X__ YES ___NO Will need to contact other agencies and branches

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) None

State None

Federal None

Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

This proposal would eliminate a reporting requirement to the General Assembly which assumes that agencies have a mechanism (an annual report) to report information on volunteers within each agency. Because most agencies do not have such a report, it means that agencies are either out of compliance or would have to create a report specifically for this data to be submitted to the generic "General Assembly" for what purposes the statute does not explain.

An Act Eliminating a Reporting Requirement

Be it enacted by the Senate and House of Representatives in the General Assembly Convened:

Section 1. Section 4-61hh of the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 4-61hh. Volunteers in state government. Definitions. As used in sections 4-61hh to [4-61mm,] 4-61*ll*, inclusive:

(1) "Volunteer" means any individual who provides goods or services to any state agency without compensation therefor;

(2) "Regular service volunteer" means any volunteer engaged in specific service activities on an ongoing or continuous basis;

(3) "State agency" shall include any agency, authority, board, commission, council, department, institution or other instrumentality of the state.

Section 2. Section 4-61ii of the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 4-61ii. Volunteer programs within state agencies. Any state agency utilizing or contemplating the utilization of volunteers shall be responsible for the development, continuation or expansion of volunteer programs within the agency. Each state agency may, for the purposes of fulfilling its responsibilities under sections 4-61hh to [4-61mm,] 4-61*ll*, inclusive, do any or all of the following: (1) Utilize qualified salaried professional staff to develop meaningful opportunities for volunteers involved in carrying out the functions of the agency; (2) develop written rules governing the recruitment, screening, training, responsibility, utilization, supervision and evaluation of its volunteers, but such rules shall not be deemed to be regulations as defined in subsection (13) of section 4-166; (3) take such actions as are necessary to ensure that volunteers and paid employees understand their respective duties and responsibilities toward one another and their respective roles in fulfilling the functions of the agency; (4) develop and implement orientation and training programs for volunteers; and (5) contract with other state agencies, as it deems necessary.

Section 3. Section 4-61mm of the general statutes is repealed:

Sec. **4-61mm**. Evaluation of volunteer program to be included in annual report. Each state agency, as part of its annual report to the General Assembly and the Governor, shall include an evaluation of its volunteer program which details the following information: (1) The total number, location and duties of all volunteers; and (2) the total number of annual hours of service provided by all volunteers.

Federal Register / Vol. 77, No. 95 / Wednesday, May 16, 2012 / Rules and Regulations

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
42 CFR Chapter IV [CMS–9070–F] RIN 0938–AQ96
Medicare and Medicaid Program; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule identifies reforms in Medicare and Medicaid regulations that CMS has identified as unnecessary, obsolete, or excessively burdensome on health care providers and beneficiaries. This rule increases the ability of health care professionals to devote resources to improving patient care, by eliminating or reducing requirements that impede quality patient care or that divert providing high quality patient care. This is one of several rules that we are finalizing to achieve regulatory reforms under Executive Order 13563 on Improving Regulation and Regulatory Review and the Department's Plan for Retrospective Review of Existing Rules.

DATES: These regulations are effective on July 16, 2012.

FOR FURTHER INFORMATION CONTACT:
Ronisha Davis, (410) 786–6882. We have also included a subject matter expert and contact information under the ''Provisions of the Proposed Regulations and Analysis of and Responses to Public Comments'' section for each provision set out in this rule.

SUPPLEMENTARY INFORMATION:
I. Executive Summary for This Final Rule
A. Purpose
In Executive Order 13563, ''Improving Regulations and Regulatory Review'', the President recognized the importance of a streamlined, effective, and efficient regulatory framework designed to promote economic growth, innovation, job-creation, and competitiveness. To achieve a more robust and effective regulatory framework, the President has directed each executive agency to establish a plan for ongoing retrospective review of existing significant regulations to identify those rules that can be eliminated as obsolete, unnecessary, burdensome, or counterproductive or that can be modified to be more effective, efficient, flexible, and streamlined. This final rule responds directly to the President's instructions in Executive Order 13563 by reducing outmoded or unnecessarily burdensome rules, and thereby increasing the ability of health care entities to devote resources to providing high quality patient care.

B. Summary of the Major Provisions
Removes Unnecessary Burdensome Requirements: We have reduced burden to providers and suppliers by modifying, removing, or streamlining current regulations that we have identified as excessively burdensome.

Intermediate Care Facilities for Individuals who are Intellectually Disabled (ICR/IID): We have eliminated the requirement for time-limited agreements for ICFs/IID and replaced the requirement with an open ended agreement which, consistent with nursing facilities, would remain in effect until the Secretary or a State determines that the ICF/IID no longer meets the ICF/IID conditions of participation. We have also added a requirement that a certified ICF/IID must be surveyed, on average, every 12 months with a maximum 15-month survey interval. This action provides States with more flexibility related to the current process.

Removal of the Term ''Recipient'' for Medicaid: We have removed the term ''recipient'' from current CMS regulations and made a nomenclature change to replace ''recipient'' with ''beneficiary'' throughout the CFR. In response to comments from the public to discontinue our use of the unflattering term ''recipient'' under Medicaid, we have been using the term ''beneficiary'' to mean all individuals who are eligible for Medicare or Medicaid services.

Replace the Term ''Mental Retardation'' with ''Intellectual Disability'': We have replaced all references in CMS regulations to the unflattering term ''mentally retarded'' with ''individuals who are intellectually disabled'' that has gained wide acceptance in more recent disability laws.

5. Duration of Agreement for Intermediate Care Facilities for Individuals With Intellectual Disabilities (Referred to in Current Regulations as Intermediate Care Facilities for the Mentally Retarded) (§ 442.15 Through § 442.109)

As described elsewhere in this preamble, we are replacing the use of the term ''mentally retarded'' with the term ''individuals with intellectual disabilities'' as described in this program, so we have used the new term in these final provisions.

Section 1910 of the Act provides for the certification and approval of Intermediate Care Facilities for the Individuals with Intellectual Disabilities (ICF/IIDs). These facilities were formerly known as Intermediate Care Facilities for the Mentally Retarded (ICF–MRs) and are renamed through the change in nomenclature described below in this rule. Current regulations at § 442.109 and § 442.110 address ICFs-IIDs provider agreements and limit the ICFs-IIDs provider agreements under Medicaid to annual time limits. We proposed to remove the time limited agreements for ICF/IIDs at § 442.16. We also proposed to eliminate this requirement at § 442.15, § 442.109, and § 442.110. In order to give more flexibility to States, we proposed to replace the requirement with an open ended agreement which, consistent with nursing facilities (NFs), would remain in effect until the Secretary or a State determines that the ICF/IID no longer meets the conditions of participation for ICF/IIDs at subpart I part 483.

Also, we proposed to add a requirement that a certified ICF/IID must be surveyed on average every 12 months with a maximum 15 month survey interval. Current regulations at 42 CFR part 442 require that ICF/IIDs be surveyed for compliance with conditions of participation at least every 12 months on a relatively fixed schedule. By contrast, nursing homes must be surveyed for compliance with certification standards at intervals of between 12 and 15 months. We anticipate the change in the certification period will have positive impacts on the care provided in these facilities because the new process will be less predictable and will require facilities to be more

proactive in maintaining high standards of care. The new process will also improve the efficient and effective operation of State survey agencies responsible for regulating ICF/IIDs.

In addition, State survey agency resources are strained by the rigid timelines imposed in the current regulation. For example, if a complaint results in an abbreviated survey 10 or 11 months into the facility's certification period, the current regulation does not allow the State agency to expand the complaint survey for the purpose of completing the requirements of annual certification at the same time. Instead, the State is required to conduct another full survey at 12 months, which is duplicative. More flexibility would allow States to use their survey staff in a targeted fashion, allocating resources where needed to assure resident safety and quality of care, rather than being forced to meet rigid regulatory timelines that do not bear a relationship to the needs of residents.

We received three public comments on our proposed changes to the duration of agreement for ICF/IID.

Comment: One commenter representing a state survey agency agreed with CMS's belief that the change will provide opportunities to increase operational efficiency at the state level by enabling more flexible scheduling and by reducing duplication when complaint survey timing may coincide with annual recertification. The commenter noted that with the proposed changes survey times would be less predictable and the expanded interval range will improve the quality improvement impact of surveys. The commenter also noted that the changes will provide a reduction in paperwork at the survey agency, the state Medicaid agency, and certified facilities, and that the additional flexibility afforded by the change will allow resources to be focused on problematic facilities and validation processes.

The commenter requested the survey time for ICF/IIDs be expanded to 24 months to provide States opportunities to focus resources on poor performing facilities.

The commenter also requested that CMS consider relaxing the requirement that surveys be unannounced. The state has recently implemented a system of announced state surveys and believes the practice contributes to improved quality improvement efforts by encouraging state agency cooperation.

Response: The commenter's observations regarding the efficiencies and process improvements afforded by this change reinforce the rationale for revising the duration of the agreement.

The change to the survey time will make ICF/IID's consistent with certified nursing facilities regarding survey scheduling. At this time CMS has not found that extending the survey time for ICF/IID's beyond 12 months on average could be accomplished without negative impacts on the quality of care delivered by these facilities. Therefore, the same standard survey time period for nursing facilities has been applied to ICF/IID's. However, the proposed change will allow states greater latitude to survey poor performing facilities more frequently and high quality facilities less frequently, as long as the overall time-frames are observed. The requirement that surveys be unannounced is intended to assure that facilities provide a consistent quality of services and care required under the conditions of participation. While announced surveys may improve state and

facility cooperation, CMS has not determined that overall program performance or the quality of care for residents would benefit by announcing survey visits.

Comment: One commenter requested that CMS allow states, through the State Performance Standards, as much flexibility as possible during the first year of implementation to modify survey schedules and thereby produce a higher level of survey unpredictability.

Response: CMS seeks to eliminate the administrative burden of the completion of forms which extend the provider agreement in cases where the survey activity has not been completed within the required 12 month period. These forms, currently exchanged between two units of State government and the provider, require administrative work without adding value or increasing the survey frequency. They also serve, to some extent, in alerting ICF/IID facilities to the prospect of an imminent survey. Therefore, in addition to reducing administrative burden the regulatory change also provides an increased opportunity for the State Survey Agencies to more greatly vary their survey schedules and to decrease the predictability of the survey visits by the provider. We agree with the commenter with regard to State performance expectations, and will ensure that the State Performance Standards for this measure will be listed as ''developmental'' to encourage the State Survey Agencies to make significant changes to their survey schedules for ICF/IID and thus enhance the unpredictability of surveys

Comment: Another commenter from a state agency expressed the concern that the 12 month average survey interval is inconsistent with the 15 month maximum time interval allowed. The commenter also expressed concern that the rule does not specify whether the state or CMS will determine the statewide average interval, nor how the state may appeal a determination of compliance with the interval if the state disagrees.

Response: As discussed above, the proposed change in the rule will make the timing of ICF/IID surveys consistent with the requirements for surveys of certified nursing facilities. Each facility will be surveyed at least once every 15 months, and facilities must be surveyed an average of every 12 months. Necessarily, this means that if some facilities are surveyed only after 12 months but before the end of 15 months from the last survey, other facilities in the state must be surveyed more frequently than 12 months. We will publish in our Mission and Priority Document (MPD) the methodology to be applied in computing the maximum and average survey intervals for ICF/IID's. While there is no formal appeal process for States to dispute the calculations included in the MPD, this methodology will be available to the states which can use it to verify CMS's calculation of the average survey interval. The above summarizes this provision as proposed in our proposed rule and the comments we received. We are finalizing the policy above as proposed.

Contact: Thomas Hamilton, 410–786–9493.

2. Replace All the Terms: ''the Mentally Retarded; ''Mentally Retarded Persons;'' and ''Mentally Retarded Individuals'' With ''Individuals With Intellectual Disabilities'' and Replace ''Mentally Retarded or Developmentally Disabled'' With ''Individuals With Intellectual Disabilities or Developmental Disabilities''

We proposed to change the terminology we use in the program currently called Intermediate Care Facilities for the Mentally Retarded. Section 1905 (d) of the Act states that, ''The term ''intermediate care facility for the mentally retarded'' means an institution (or distinct part thereof) for the mentally retarded or persons with related conditions * * *.'' In 2010, Rosa's Law (Pub. L. 111–256) amended statutory language in several health and education statues, directing that ''in amending the regulations to carry out this Act, a Federal agency shall ensure that the regulations clearly state—(A) That an intellectual disability was formerly termed ''mental retardation''; and (B) that individuals with intellectual disabilities were formerly termed ''individuals who are mentally retarded.''

CMS regulations at 42 CFR chapter IV include numerous references to ''mental retardation.'' These regulatory provisions reflect the statutory benefit category at section 1905(d) of the Act, which uses the term ''mental retardation'' in the facility type designation, ''Intermediate Care Facility for the Mentally Retarded.'' Rosa's Law did not specifically list the Act within its scope, and therefore did not require any change to existing CMS regulations. However, consistent with Rosa's Law and in response to numerous inquiries from provider and advocate organizations as to when CMS will comply with the spirit of Rosa's Law, we proposed to adopt the term ''intellectual disability'' (as used under Rosa's Law) in our regulations at § 400.203. We proposed to define the term ''individuals with intellectual disabilities'' to mean the condition referred to as ''mentally retarded'' in section 1919(e)(7)(G)(ii) of the Act. This nomenclature change does not represent any change in information collection requirements or other burden for the provider community or the State survey agencies. Current forms may be used by the State survey agencies until current supplies are exhausted. The change will require revision of forms CMS–3070G and CMS–3070H, as discussed below.

We received four public comments on our proposed nomenclature change, changing ''mental retardation'' to ''intellectual disability.''

Comment: One commenter expressed appreciation for the effort to change the term. He recommends that person-first terminology ''individuals with intellectual disabilities'' be substituted for ''intellectually disabled.''

Response: We appreciate and agree with the comment that the term ''individuals with intellectual disabilities'' is preferable to ''intellectually disabled'' and CMS will use ''person first'' language in our agency policies and our internal and external communications. The nomenclature changes included in the NPRM were, by design, intended to make the current nomenclature in the regulation consistent with the language of Rosa's Law (Pub. L. 111–256). After due consideration of the commenter's suggestion, we believe that reasonable consistency with Rosa's law can be maintained with the adoption, in this final rule, of ''person first'' language, and have made the change accordingly. In the rule itself, we therefore use the term Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) in place of Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

Comment: Two commenters ask for clarification of the definition of Intellectual Disability. The commenters suggest that CMS is unclear when it defines Intellectual Disability to be equivalent to the term Mental Retardation. They point out that the definition of Mental Retardation at 42

CFR 483.102(b)(3) is from 1983 and is no longer in use. Furthermore, the definition in the Social Security Act still references Mental Retardation and the rule has no effect on that definition. In addition, one commenter notes that in medical usage the terms mental retardation and intellectual disability are not equivalent.

Response: The rule's intent is to extend the intent of Rosa's Law, that ''in amending the regulations to carry out this Act, a Federal agency shall ensure that the regulations clearly state—(A) That an intellectual disability was formerly termed ''mental retardation''; and (B) that individuals with intellectual disabilities were formerly termed ''individuals who are mentally retarded'' to include those regulations that implement the Social Security Act. While the term ''mental retardation'' has various definitions in a variety of contexts, and those definitions may have varied over time, within 42 CFR chapter IV the term has uses in determining benefit eligibility and describing provider types. The change simply makes the terms mental retardation and mentally retarded equivalent to intellectual disability and individuals with intellectual disabilities, respectively, for the purposes of the regulations.

Comment: One commenter notes that the term Mental Retardation also appears in Chapter V at 42 CFR 1001.1301.

Response: We thank the commenter for finding this omission and will review the Chapter V reference for future action.

Comment: One commenter correctly notes that the rule has no effect on the language in section 1919(e)(7)(G)(ii) of the Act.

Response: Making this change to the Act will require legislation. We believe that the Congress will consider doing so in the future. Meanwhile, cross references can be changed as necessary.

Comment: One commenter correctly notes the incorrect use of ''title'' for ''chapter'' in the discussion.

Response: This error has been corrected.

Comment: One commenter notes that the change might have unintended consequences if applied to historical references.

Response: We will review the suggested sections and make changes if necessary to avoid confusion regarding the meaning of the term as used in the regulations.

The above summarizes this provision made in our proposed rule and the comments we received. We are finalizing the policy above as proposed, while adopting a commenter's suggestion of using person-first terminology.

Contact: Peggye Wilkerson, 410–786–4857.